UNDERSTANDING OBAMACARE

POLITICO's Guide to the Affordable Care Act

By David Nather

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Introduction

What the Fight's Really About

If you want to cut through all of the noise and just get to the bottom line of what the fight over President Barack Obama's health care law is really about, you can learn a lot through the stories of two Georgia Republicans.

One wants to wipe Obamacare off the books. The other says he needs it to stay alive.

Clint Murphy is a real estate agent in Savannah who used to be a Republican political operative. He's also a survivor of testicular cancer, which means he can't get health insurance now. The only way he'll be able to get it, he says, is through the Affordable Care Act — otherwise known as Obamacare.

When open enrollment for Obamacare coverage begins on Oct. 1, Murphy will be able to sign up for health insurance,

and the insurer won't be able to turn him down for having a pre-existing condition. That's why he has been telling his story to media outlets and working with the law's biggest supporters to make sure Obamacare survives. He's tired of being uninsured.

Tom Price is one of the House Republicans who keeps voting, over and over, to get rid of the law or starve it to death. But Price doesn't want to just be a wrecking ball. The orthopedic surgeon is the author of one of the only fully developed Republican alternatives to Obamacare, and he has been talking it up every chance he gets.

Price has heard Murphy's story, and has total sympathy for him. It's "terrible," Price says, to be locked out of the health insurance market like that. But Price says he has a better answer for Murphy: create special health plans that would be offered through membership associations.

"If we made it a goal that [people with pre-existing conditions] would have access to pools of health insurance with millions of others, ... then you've solved the problem without putting Washington in charge," Price said.

Murphy's response: That's nice, but Obamacare is already the law. It's time to move ahead and make the law better — be-

cause everyone knows it's not going away.

"Get off of this 'my way or the highway,'" Murphy told POLITICO. "This stagnation they're creating, it has a real cost to the rest of us. The stakes are literally life and death."

That pretty much sums up the battle lines the entire nation faces as Obamacare opens for business. Part of the nation wants to throw the law out. Even if they don't want to shut down the government or default on the debt limit, they hate the law and see it as an expensive disaster. The other part is siding with the Democrats: Enough, already. Get on with it.

But even now, the reality is that much of the country still doesn't understand the law. In a Washington Post poll in September, 62 percent of Americans said they don't have the information they need to understand the law. It's just too massive for most people to untangle everything in it.

That's why POLITICO has put together a new guide to the health care law, timed to the launch of open enrollment — when Obamacare will finally become real to millions of Americans.

POLITICO's guide to Obamacare is designed to be a reality check on how the law is supposed to work and how it might actually work. It's intended to serve two goals: explain the law

and help you read between the lines of the most common talking points to find the truth.

The Obama administration is still convinced the law will become more popular when people see it in action — but right now, it's still divisive and unpopular. In the Post poll, 52 percent of Americans said they oppose the law while just 42 percent support it.

That doesn't mean they want to stop it at all costs. Only a third of Americans in a Pew Research Center poll in September wanted to shut down the government to stop Obamacare — driven largely by the strong support of tea party Republicans — while 57 percent said Washington should compromise.

But that's not going to help the White House close the sale on the law itself. The challenge for the Obama administration, over the six months of "open enrollment" and the years to come, is to win converts from the millions of Americans who are skeptical about the law — and make sure all of the moving parts work the way they're supposed to.

The new health insurance marketplaces have to sign up the right mix of people. The subsidies have to flow to the right people. The spending cuts and taxes have to be enough to pay for them. Employers have to understand the new rules and

not get crushed by them.

It's no wonder that people are still trying to understand how the law will affect their lives, because the debates they hear — in Washington and at political rallies throughout the country — tend to be completely one-sided. You either hear that Obamacare is a lifeline to millions of uninsured people, and anyone who has a problem with it is cold-hearted, or that it's a huge headache for businesses and doctors everywhere.

The reality, though, is that it's possible to see how the health care law could help millions of Americans who need help — and how it can still be a huge headache for businesses and doctors everywhere.

That way of understanding the law may not change anyone's mind. But it may make the debate better informed, and less shrill, than it is now.

And either way, you'll have a better sense of the impact the law will have — not just the statistics, but the way it will affect people's lives.

Earlier this year, Murphy said, he went to see his doctor about breathing problems. The doctor wanted to him to have an angiogram, which is used to check the flow of blood in an artery. Murphy couldn't afford it — he's uninsured. He could

pay for a visit to the doctor but not an expensive test. He said no and walked out.

Everything turned out OK in the end, but it could just as easily have ended badly — especially for someone who has survived cancer and is hoping no other disaster strikes. The episode got Murphy more fired up about the Obamacare debate than ever.

"They're treating it like a game, like there's no people involved," Murphy said. "They need to start looking at what really happens. I'm not a statistic. I'm a real person."

There's no chance of the Obamacare debate ending anytime soon. But if any debate ever needed a reality check, it's this one.

I

The Big Change: Covering Pre-Existing Conditions

If you've listened to President Barack Obama and the Democrats talk about the need for Obamacare, it may be hard to tell what the law is "about."

Lower costs? Whacking the insurance companies? Covering young adults? Covering contraceptives? The sales pitch has changed over the years, sometimes from speech to speech.

But perhaps the biggest change for consumers, as the law becomes part of their everyday lives, is also the benefit that may give the Obama administration its biggest chance of closing the sale: the coverage of adults with pre-existing conditions.

This is one of the biggest pieces of the law that is supposed to start in 2014, and it will be a huge selling point when Demo-

crats talk about the benefits. When you sign up for Obamacare coverage — which is aimed at people who don't get health insurance through the workplace or other sources — the insurers won't be able to turn you down if you have health problems, or charge you more because of them.

Children with pre-existing conditions are already covered — that part of Obamacare took effect in September 2010. But adults with health problems are more expensive to cover, because people are more likely to develop chronic conditions or other issues as they get older. That's why adults couldn't be covered until the rest of the law was in place, so the cost of their illnesses could be spread among a larger population of sick and healthy people.

There are a lot of things for critics to hate about the law — the individual mandate, the cuts in Medicare payments — and every problem with the rollout will get a harsh spotlight. But most Republicans aren't complaining about the pre-existing condition coverage. That's because pre-existing conditions affect enough people — from all political parties, in all parts of the country — that it's hard for them to attack the law on those grounds.

There's no broadly accepted estimate for how big the prob-

lem is. A 2011 study by the Department of Health and Human Services said the number of people with pre-existing conditions could be as low as 50 million non-elderly Americans or as high as 129 million, which is a pretty wide range. But even if you use the lowest number, 50 million, that's almost one out of five Americans under age 65, including 25 million who are uninsured.

Conservatives don't think that many people have actually been shut out of coverage. The American Enterprise Institute's Tom Miller, for example, estimates that only 2 million-4 million Americans have been blocked from getting coverage because of their health. He says a lot of the uninsured people identified by HHS might lack coverage for reasons that have nothing to do with pre-existing conditions.

Still, the prospect of not being able to get coverage because of a health problem is deeply scary to people of all political stripes. That's the message Clint Murphy, a former Republican operative in Savannah, Ga., who survived testicular cancer, sent in his widely publicized Facebook post aimed at Republicans who want to defund Obamacare.

"I'd say there's a lot more of us than people think," Murphy said. When someone has been through an illness like cancer

— or even when they just have a common condition like high blood pressure — it becomes harder to leave the security of a job with a group health plan that covers pre-existing conditions, he said.

"If you're in a group environment, you can get in a group plan. So it's not an issue for you," Murphy said. But if someone with a health condition wants to start a business — or switch careers to become a realtor, where there's no easy access to a group health plan — "this really becomes a big barrier," Murphy said.

Republicans in Congress, however, say there are other ways to cover pre-existing conditions without remaking the insurance market the way Obamacare does. That's the idea behind the bill by Rep. Tom Price of Georgia, which is one of the few GOP alternatives currently in the mix. It would let people with health issues get their coverage through trade associations, alumni associations and other groups that could also spread the costs of sick and healthy people.

That way, people who join those associations couldn't be rejected for pre-existing conditions "for the same reason that Coca-Cola or UPS or Home Depot doesn't turn you down — you're part of a larger group," Price said.

But a House vote on Price's bill — or other GOP alternatives, like the one by the conservative Republican Study Committee — would present its own problems, since Republicans don't all agree on whether it's smart to offer an alternative. Many would rather just keep the focus on Obamacare and see if it collapses. So that leaves Obamacare as the only real player on pre-existing conditions.

So, given that Obamacare faces no serious prospect of being derailed or replaced at the moment, how would the law actually work? Here are some key points:

The new coverage rules

You can't just wait until you get sick and then sign up — you'll have to join a health insurance plan during one of the "open enrollment" periods, just like you would if you get health insurance at work. For this year, that's Oct. 1-March 31.

If you don't sign up then, you'll have to wait for the next open enrollment. They'll happen Oct. 15-Dec. 7 every year, although you can sign up at other times if you have a "qualifying life event," like getting married, changing jobs or moving to another state.

The two big parts of the new rules to know: Under "guar-

THE NEW COVERAGE RULES

When people buy health coverage on their own and in small groups, as of Jan. 1, 2014, health insurers won't be able to charge them more if they have pre-existing conditions. They'll only be able to charge people different prices based on other factors.

ALLOWED

Insurers can consider:

- Whether it's individual or family coverage
- Where the person lives
- How old the person is*
- Whether the person uses tobacco**

* Prices can't vary by more than 3 to 1
** Prices can't vary by more than 1.5 to 1

Source: Final rule, p. 13436

anteed issue," people who get health insurance on their own can't be turned down because of pre-existing conditions. The insurer also has to let you renew your coverage from year to year, with a few big exceptions, like if you didn't pay your premiums.

And under "community rating," the health insurance company can't charge you higher premiums if you have health problems. It can only change the price of your coverage for a few other reasons — such as whether your plan covers just one

person or the whole family, whether you use tobacco and how old you are. But it won't be able to charge older people more than three times as much as it charges younger people.

It's supposed to fix one of the main problems people have faced when they buy health insurance on their own. If you get covered through the workplace, you're usually OK even if you have health problems — you get your coverage, maybe with a waiting period.

But under pre-Obamacare rules, if you had to buy health insurance on your own for any reason — like you have your own business, or you're an independent contractor or your employer just doesn't offer it — you could be rejected for conditions as common as asthma or high blood pressure. Or you'd just be given a price so high you couldn't afford the coverage.

So what's the downside? If the health insurance companies can't charge you more for your heart murmur, that's great news for you — but they can just charge everyone a little more to cover their costs. So don't be surprised if insurance for healthy people is more expensive than it was before. That's the tradeoff for making sure sick people don't have to pay huge amounts more than everyone else.

The other goodies

Pre-existing condition coverage isn't the only "goodie" in the law. It's also making sure that health insurance covers more stuff. For example, all health plans for individuals and small groups — like small businesses — will have to cover at least 10 categories of "essential health benefits." They'll include basics like emergency care and prescription drugs, but also benefits that weren't always covered by individual health insurance before, such as maternity care and mental health and substance abuse services.

There are also other benefits that have already taken effect — like requiring health plans to cover recommended preventive services, like vaccinations and blood pressure, cholesterol and certain cancer screenings. There's the rule that allows young adults up to age 26 to stay on their parents' plans. The new law phases out annual limits on those minimum benefits, too.

Those benefits have given Obama lots of other talking points about the law. Another big selling point: those rebates consumers get when health insurance companies spend too much on overhead and not enough on actual medical care. If they don't spend at least 80 percent of your premiums on

medical care for individual or small-group insurance — or 85 percent for large-group insurance — they have to write you or your boss the rebate check.

Obama is also getting a lot of mileage out of the law's Medicare benefits — which include the closing of the "doughnut hole," the big gap in Medicare prescription drug coverage that used to require seniors, after they'd racked up enough costs, to spend $3,610 on their own before their coverage picked up again. The law is phasing out that gap, and it's supposed to be gone by 2020.

And yes, Obamacare requires health plans to cover FDA-approved contraception, as prescribed by a doctor, without cost to the patient. There's an exception for religious employers, and nonprofit religious organizations that object to the coverage don't have to pay for it directly — the Obama administration is working around that by sticking the insurance companies with the bill.

But that hasn't stopped the steady stream of lawsuits from religious groups that say the compromise doesn't really take care of their moral objections, and from businesses that don't count as religious employers but say they still object on religious grounds.

As you try to figure out the impact Obamacare has on you and your family, you're going to be treated to all kinds of claims and counterclaims about what the law does and doesn't do as well as its consequences, intended or not.

Some common arguments, with our truth-squadded analysis:

What you'll hear: All of these new Obamacare rules are going to lead to "rate shock."

Reality check: The threat of big increases in health insurance premiums isn't made up, but it's usually exaggerated.

The idea is that Obamacare requires health insurers to cover so many new things — not just pre-existing conditions, but the new benefits and the other goodies — that the price of health insurance for individuals is going way up. Ohio says its average premiums for individual coverage will be 41 percent higher in 2014 than they were in 2013. Indiana says its average premiums will be 72 percent higher.

And Georgia? Its insurance commissioner says some people could pay as much as 198 percent more than they used to — although even the insurance commissioner, Ralph Hudgens,

admitted that was an extreme example.

But yes, health care experts say, some people who buy health insurance on their own will get a higher sticker price than they used to. It's likely to be the healthiest people, though, and usually the ones who had skimpier health insurance that barely covered them. And that doesn't count the Obamacare subsidies that will bring the prices down for a lot of people.

"The spin across the states varies a lot more than the rates do," said Larry Levitt, a senior vice president at the Kaiser Family Foundation, who has studied the insurance rate filings throughout the states. Overall, he said, "the rates look quite reasonable for what insurers have to cover and the rules they have to follow."

Mark Pauly, a health economist at the University of Pennsylvania, says "there's going to be a bump" for healthy people who won't get discounts anymore — but "I don't think it's going to be as humongous as the numbers some people are quoting."

A study of 10 states by the RAND Corporation, sponsored by the Department of Health and Human Services, concluded that there wouldn't be huge price increases across the country, but that some states would see some pretty big rate hikes.

It depends on how many uninsured people the state has, the study found, because states where most people already have health insurance won't be able to add as many new, healthy people to pay for the sick ones.

Ohio was one of the states that would see big increases, RAND found, because it doesn't have a lot of uninsured people. But five states — Florida, Kansas, Pennsylvania, South Carolina and Texas — weren't expected to see any increases, and two — Louisiana and New Mexico — could actually see their prices go down.

In some ways, it's hard to compare the old prices with the new ones, because many people in the pre-Obamacare individual market could get cheap, "bare bones" plans that were only useful in real medical emergencies. Some had a $10,000 deductible, meaning coverage wouldn't kick in until you had paid that much out of pocket.

People who bought that kind of health insurance might have to pay more now, but only because they had coverage "that doesn't cover a lot of the things they think it will," according to Austin Frakt, a health economist at Boston University.

"There will be people like that. We'll be able to find them," said Frakt. But the idea that most Americans will see huge

price increases, he said, is "overblown and distorted."

Obamacare critics, however, say that tradeoff of better benefits for higher premiums still violates the deal Obama offered voters when he ran for president in 2008 — that families would save as much as $2,500 on their health insurance.

"Candidate Obama did not promise that 'you will pay more for insurance, but you will get a better health plan in return.' He explicitly promised that 'you will pay less,'" Chris Jacobs, a senior policy analyst at The Heritage Foundation, wrote in a critique of Obamacare premiums.

Remember, though, that many people aren't going to pay the sticker price. Obamacare provides subsidies for low-income people to help them buy health insurance, and there's some help available for people with incomes as high as 400 percent of the federal poverty level, which is a bit more than $90,000 for a family of four. So those subsidies could mask some of the rate increases.

"There's little question that the sticker prices under Obamacare will be higher than what people pay today. The coverage, in many cases, will be better, and people with pre-existing conditions will be able to get coverage, which they can't today," said Levitt. And after the subsidies are factored in, he

said, those prices "will, on average, go down."

What you'll hear: It'll draw all the sick people, raise healthy people's premiums and lead to a "death spiral."

Reality check: The "death spiral" is an outcome critics say is bound to happen if people wait until they're sick to sign up for health coverage, since the health insurance companies have to accept them. That makes everyone else's premiums go up, so the healthy people leave, and premiums go up even more because only the sick people are left.

But this scenario doesn't account for Obamacare's controversial "individual mandate," which requires everyone to get health coverage. If the individual mandate does its job, it should bring in enough healthy people to cushion the blow.

Some Obamacare critics have warned about the spiral, because pre-existing condition coverage has led to disastrous premium hikes in states that have tried it before. That's what happened in New York, which guaranteed coverage for everyone with pre-existing conditions and now has some of the highest individual health insurance premiums in the country.

But Massachusetts did that too, except it also had one thing the other states didn't have: an individual mandate. That was

the formula of the state's 2006 health reform law — the one signed by Mitt Romney.

A 2011 study by three health analysts — including MIT's Jonathan Gruber, who consulted on the Massachusetts law — found that there was a huge increase in enrollment by healthy people right after the Massachusetts mandate took effect, even bigger than the number of sick people who signed up for coverage.

Will Obamacare work out the same way? Not necessarily – the study's authors noted that the subsidies to help people buy health coverage are larger in Massachusetts than they are with Obamacare. So there's less of an incentive for the healthy people to sign up for Obamacare.

There's still one big incentive the other states didn't have, however – the kick in the pants that you get with the individual mandate. Based on the Massachusetts experience, though, that could be enough to save Obamacare from the death spiral.

What you'll hear: There are other ways to cover pre-existing conditions.

Reality check: Most Republicans don't think the entire

Obamacare overhaul was necessary to solve the problems of people with pre-existing conditions. That's why they like the idea of covering them through separate "high-risk pools," one of the ideas Romney highlighted in his presidential campaign. But those are expensive – and not even all Republicans agree that they're the right answer.

And even if they did, Obamacare's own experience shows what happens if Congress doesn't give them enough money.

The law set up a program called the "Pre-Existing Condition Insurance Plan," which set up high-risk pools specifically to cover people with health problems. Those were layered on top of the high-risk pools that were already being run by 35 states, under different rules. The idea was to give people with health problems a temporary source of coverage between 2010, when Obamacare was signed into law, and 2014, when they'd be able to get into regular health insurance plans.

The problem was, Congress only budgeted $5 billion to fund Obamacare high-risk pools for that whole time – and it wasn't enough, since people with pre-existing conditions have expensive health needs. In February, the Obama administration stopped taking new applications.

So how much money would it take to get thriving high-risk

pools up and running in all the states, in place of Obamacare? Miller figures it would take somewhere between $5 billion and $10 billion a year, depending on how they're designed — how generous the coverage would be, how much freedom the states would have to design the rules, and whether customers would have to prove they'd been rejected by another insurer.

That may be more than deficit-minded Republicans would want to spend, though. Romney never got specific about how much money he would have put into the risk pools. And Price's bill sets aside $300 million a year for three years for the risk pools and related measures — way less than Obamacare spent.

"That's too low," Miller said. He says he has told Republican lawmakers that "you need to put more money in if you want to have a credible high-risk pool solution."

But Price says there's a reason he didn't put more money into the risk pools: He doesn't think they really work. They're just a "stopgap" measure, he said, and the real goal should be to set up new ways for people with health problems to get insurance through larger groups — not dump them all into risk pools with other sick people.

Price says his bigger goal is the creation of the "individual

membership associations," which would let people join larger groups that they might join anyway — like civic groups, trade associations or churches — and spread the cost of their care that way. These organizations would be able to get group health plans that couldn't turn people down for pre-existing conditions, and they'd be cheaper than others because they wouldn't have to offer all the benefits many states require them to offer, Price said.

Price acknowledges that "the reason it's hard for people to get their arms around [the idea] right now is that it doesn't exist yet." But the biggest practical problem with the idea, critics say, is that people don't voluntarily join a group health plan in big enough numbers to cover the costs of sick people. That's why it takes stronger measures to get the right mix of sick and healthy people.

"If you just put up a sign that says, 'Groups form here' — so? There's nothing magic about that," said Karen Pollitz of the Kaiser Family Foundation, a former Obama administration official who has studied the individual insurance market for years. "The notion that we can somehow get a health plan to pool itself because it's nice, that has never happened in the individual market. We've been at this for a long time."

As for Murphy, he doesn't think it's a bad idea. He just thinks it's something Republicans should put on the table as a way to improve Obamacare — not get rid of it.

"You have to address the whole problem," Murphy said. "No one should be excluded for pre-existing conditions. End of discussion."

II

The Tradeoff: The Individual Mandate

So you want that pre-existing condition coverage? There's a price for it: the individual mandate.

That's the way Obamacare was designed. The mandate requires nearly everyone to get health coverage — whether it's through their employer, through Medicare or Medicaid or on their own — or risk paying a penalty. The goal: Make sure enough healthy people sign up for coverage to help pay for the sick people.

That's the way the Obama administration defended the individual mandate to the Supreme Court, and the court decided to let the mandate stand. So starting in 2014, most Americans will be required to have health insurance. Most of them — as many as 86 percent — already have health coverage that counts. But if they don't, they'll have to get it.

There are some real penalties if you ignore the mandate. And by the time it's in full force, in 2016, the best official projections show that more than 6 million Americans will have to pay the fines because they didn't get health coverage, according to the Congressional Budget Office, which did all of the detailed analysis of the law for Congress.

Health insurers pushed for the mandate when Obamacare was passed, to balance out the new requirements to cover sick people, but now they're holding their breaths. The administration has never been able to convince all health experts — or insurers — that they'll pull in enough healthy people to cover the new costs for sick people.

"The penalty really is quite small compared to the premiums," said economist Mark Pauly of the University of Pennsylvania.

Sure, the individual mandate worked in Massachusetts — the state that passed the health care reform law that was the model for Obamacare. It got a big influx of healthy people right after its own mandate went into effect. But even economists who think the Obamacare mandate penalties are strong aren't sure other states will react the same way.

After all, will Texans really rush out to embrace the man-

date? What about in Missouri, where voters approved a ballot measure rejecting the mandate?

"The cultural climate is very different in other states," said health economist Austin Frakt of Boston University. "I don't think the individual mandate is going to be strong enough to overcome the cultural resistance in some of the states."

For all the screaming about the individual mandate, it isn't going to touch the lives of the vast majority of Americans.

You don't have to worry about the mandate if you already have health coverage, and 86 percent of Americans under age 65 have one of the kinds of coverage that satisfies the mandate, according to the Urban Institute, a liberal think tank. That includes people who have health insurance through the workplace or get it through Medicaid or the Children's Health Insurance Program, all of which count under the law. And seniors are covered through Medicare, which also counts.

And of the 30 million Americans who will still be uninsured in 2016 — the group that might have to worry about the mandate — the Congressional Budget Office says some will be exempt from the fine, because of low incomes or other reasons, while others are undocumented immigrants who are aren't eligible for Obamacare anyway.

There will be exemptions available for Native American tribes, people who had financial hardships (like a death in the family or bankruptcy), those who were only uninsured for short period of time and people who belong to religious groups that reject all insurance benefits, among others.

How the fines work

That brings us to the 6 million who will pay the fine if they don't get health insurance. The penalties aren't going to give anyone night sweats for the first two years. After that, the fines will grow — but the chances are, it'll still be cheaper than buying health insurance.

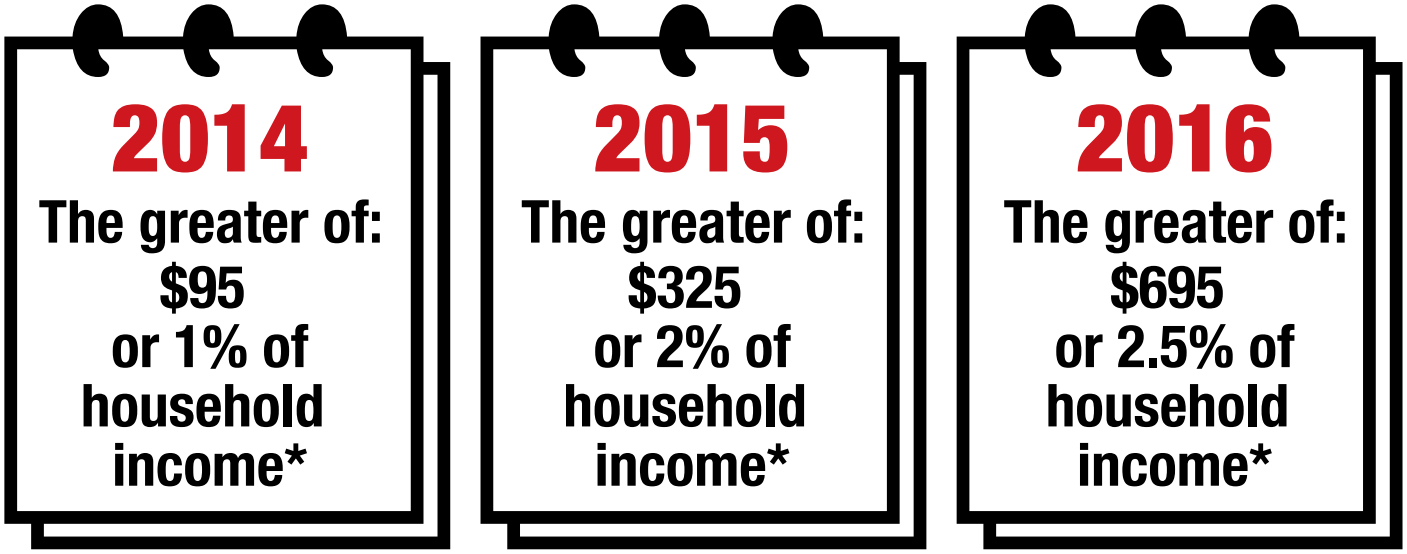
When the fines start in 2014, people who don't get health coverage would pay $95 or 1 percent of their household income, whichever is greater. That rises in 2015 to $325 or 2 percent of their household income.

The full penalty doesn't start until 2016. By then, it's $695 or 2.5 percent of their income, whichever is greater. There's some fine print and limits in different situations, but that's the easiest way to understand it.

That can lead to some pretty hefty penalties, but only for people who earn a lot of money — so it would have to be, say,

HOW THE INDIVIDUAL MANDATE FINES WORK

Here's what the penalties will be for people who don't have health insurance that satisfies the mandate (workplace health insurance, individual coverage, small-group coverage, Medicare, Medicaid, CHIP, etc.) and don't get an exemption:



* The fine is based on the "excess income," which means everything over the filing threshold – the level at which people have to file taxes.

Source: Individual mandate final rule, pp. 69-70

the lawyer or consultant who's raking it in but just doesn't want to buy health insurance. Here's how the IRS describes it in the regulations: If you're a single person with no kids, and you're earning $120,000 a year, you'd pay a $2,700 fine, because that's based on your income and it's higher than the $695 you would have paid otherwise.

But all of the IRS examples are based on people with high incomes — way higher than the average American. To find out what the fines would be for a normal person — someone living

in, say, Ohio and earning the median income — POLITICO did its own calculations of more realistic scenarios. The calculations, confirmed by Larry Levitt of the Kaiser Family Foundation, show that the more typical penalties would range from hundreds of dollars to the low $2,000 range.

For a single person in Ohio earning $45,000 a year — roughly the median income in the state — the individual mandate penalty would be $875. That's the income-based fine, and that's the one that would be charged because it's higher than the flat-rate penalty, which would be $695.

For a family of four in Ohio, however, the math works differently. A family that earns $73,000 a year — which is about the median income for a family of four — would be charged $2,085, the flat-rate penalty. In that case, it's higher than their income-based penalty, which would have been $1,325.

They'd pay the penalty when they file their tax returns, but what can the IRS do if some scofflaws don't pay it? Not much — there are no criminal or civil penalties in Obamacare, and all the agency can really do is withhold money from their refunds, if they happen to have one coming.

Some of the common complaints about the mandate and

their level of accuracy:

What you'll hear: It won't work, because it's cheaper for young adults to pay the fine than buy coverage.

Reality check: It's true — it's probably going to be cheaper in most cases to just pay the penalty. And that may be what some people do. But the jury is still out on whether that's what most uninsured people will do.

In California, for example, a 40-year-old single mother with three children who gets by on $35,000 a year would likely have to pay $1,368 a year for the second-cheapest level of Obamacare plan — called a "silver" plan — after Obamacare's subsidies are factored in, according to Covered California, the state's new health insurance marketplace. But a 45-year-old single person who earns $50,000 could expect to pay $3,984 a year in premiums, and he or she wouldn't qualify for any subsidies.

So it could be more attractive for some people to just pay the fine. But then they'd have to decide whether that's really better than spending more money and actually getting health coverage for it, according to Levitt.

"The penalty will always be less than the cost of coverage,

but you don't get anything for the penalty. It's kind of money down the drain," Levitt said.

Insurers around the country are having to make their own predictions about whether the mandate will bring in enough healthy people to offset their costs. But Pauly notes that in California, insurers have priced their premiums with the expectation that the mandate will work. "They're betting on it," he said.

Others are just crossing their fingers.

"There's always been a concern that, given where the mandate penalties are, there is an incentive for some healthy people to pay the fine and buy the insurance after they need it," said Robert Zirkelbach, a spokesman for America's Health Insurance Plans, the main trade group for health insurance companies.

But rather than pushing Congress for bigger fines, the group's lobbying agenda is now focused on what's needed to keep health insurance premiums as low as possible — because if an uninsured person can get health insurance for not much more than the cost of the fine, they're more likely to make the jump and buy the coverage.

"The more affordable the coverage is, the more effective the

mandate is," Zirkelbach said.

What you'll hear: Now that the government can make you buy health insurance, get ready for the broccoli mandate.

Reality check: That was the refrain during the lawsuits over the individual mandate, after Judge Roger Vinson — one of the judges who ruled that the mandate was unconstitutional, before the Supreme Court upheld it — asked whether the federal government could make everyone eat broccoli because its powers would be endless.

The reality, though, is that no one in Congress is coming anywhere close to mandates again. The "slippery slope" argument only works if lawmakers become emboldened to require people to do more and more things. Right now, everyone is so exhausted from the Supreme Court fight that the only time the individual mandate comes up is when House Republicans attack it, like they did with the recent House vote to delay it.

Most Democrats still defend it when pressed, but they're not pushing for anything more. Even health insurers know it's a dead issue. Do you know what they're going to do if it turns out the mandate penalties really aren't strong enough? They're going to live with it.

III

How You'll Get Health Insurance

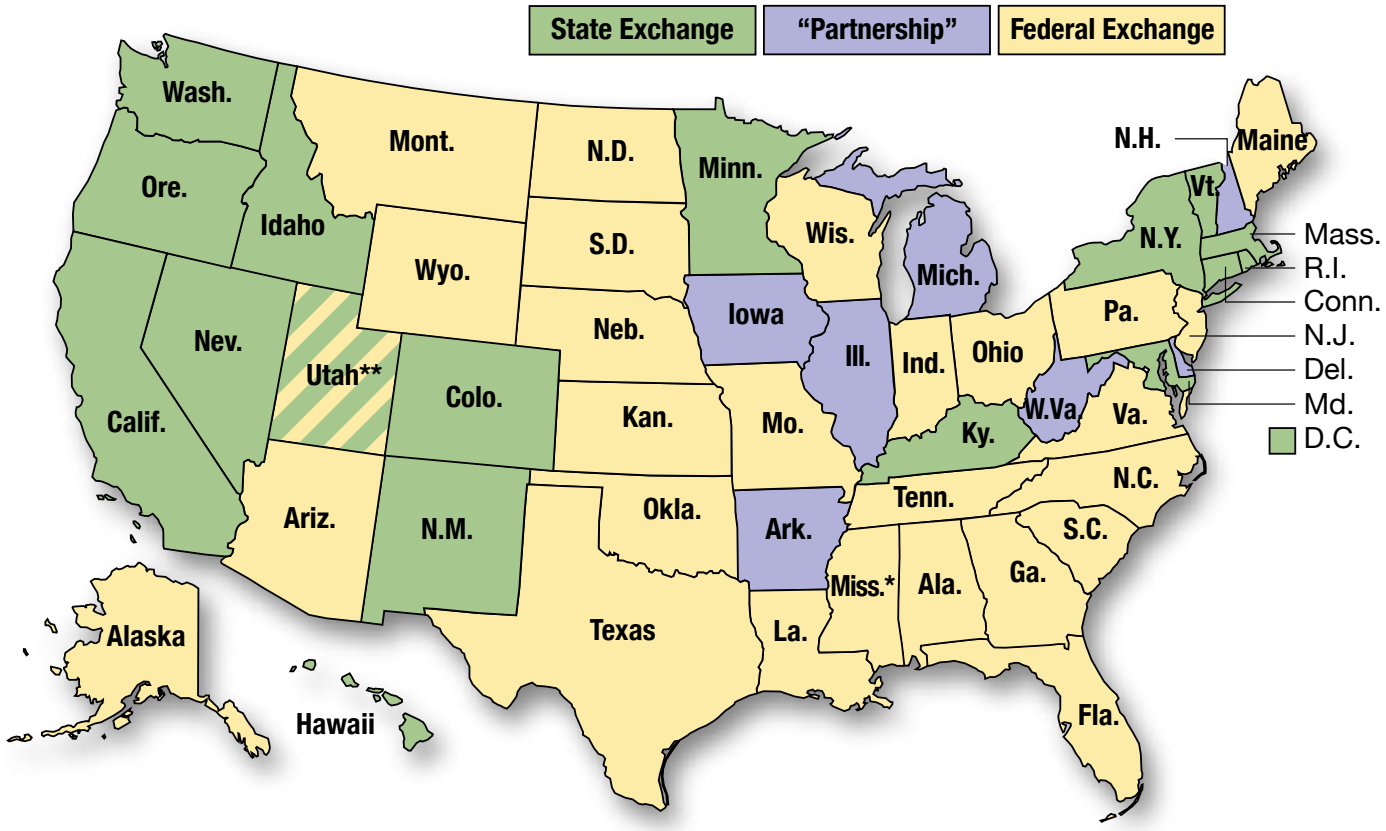
When the Obamacare law was being drafted, Democrats had to give the states a big role in carrying it out — because otherwise they never would have gotten the votes of the moderate Senate Democrats they needed to pass it.

So how did that work out? Pretty much as you'd expect when one party creates a major new social program. The blue-state governors are trying to make it work. The red-state governors, with a few exceptions, are sitting it out — meaning the feds have to come in and get it done.

That means the system you'll use to get health insurance, if you don't have it already, will be under a lot of strain.

The centerpiece — new state-based marketplaces of health

WHO'S RUNNING THE HEALTH EXCHANGES



* Mississippi's insurance commissioner, Mike Chaney, is talking to the Obama administration about setting up a state-run exchange just for small businesses.

** Utah has a federal exchange for individuals and a state exchange for small businesses only.

JULIA HASLANGER — POLITICO

insurance across the country — aren't so state-based after all. Only 16 states and the District of Columbia are running their own. Another seven are sharing the work with the federal government. The feds are running the rest all by themselves.

It's one of the biggest surprises to Democrats, considering that they always thought the marketplaces — also called exchanges — were one of the most Republican-friendly ideas in

the whole law. They're based on the idea of competition and choice among private health insurance plans, the thinking went, and they've already had a successful trial run in Massachusetts under Mitt Romney's health reform law.

None of those were strong enough arguments to overcome the practical challenges of building the exchanges in time — which is why some have faced a series of last-minute technical delays.

"This is one of the biggest IT projects ever initiated by the federal government," said Dan Schuyler, director of exchange technology at Leavitt Partners, which has been consulting on the development of the marketplaces. When the first set of federal rules came out, Schuyler said, "the first thing I said was, 'Three and a half years is not enough time to do this.'"

But even without the logistical challenges, there was always going to be a huge political obstacle: Many leading Republicans believe that even if exchanges are a good idea, they shouldn't be required under a national law.

Even Florida Sen. Marco Rubio, one of the most hard-core opponents of Obamacare, tells POLITICO he's not opposed to the idea of health exchanges to give people easy-to-compare choices of health plans. He notes that he even endorsed the

idea as part of his book, "100 Innovative Ideas for Florida's Future." But "when it's part of a national requirement ... that's a problem," he said.

How the exchange works

The general idea is this: If you don't get health insurance through the workplace or another source, you'll have a new marketplace of choices, something like an Expedia for health insurance, with private health plans for most people and an easy way for low-income customers to sign up for Medicaid. And for people who earn too much to qualify for Medicaid, but not enough to buy coverage without draining their bank accounts, there will be subsidies to help them buy it.

But wait, you say — aren't there already some websites where you can do that? Like eHealthInsurance? Well, yes, but those were just listings of what's already out there. They didn't set any rules for the health coverage, and they didn't give any financial help to people who can't afford it.

And even then, all they could do was quote you some standard prices that you might get for a health plan. Once you actually applied, and filled out that lengthy medical questionnaire — the one where they ask you to remember all the times

you've been sick over the past five years — the actual price you get might have been very different, if you get accepted at all.

Now, since you can't be rejected because of your medical history and the exchanges can't price you based on your health, it's much more likely that you'll get a price quote that reflects what you'll actually be charged. (There will be a role for eHealthInsurance in the new world: It's going to sell insurance plans for the federally run health exchanges.)

"That will be a major change," said Larry Levitt of the Kaiser Family Foundation. "It won't be point and click, but you won't have the kinds of hidden surprises that you find today."

There will be a lot of differences between the websites of the states that are running their own exchanges, especially in the design and the way the different tools are set up. In the 26 states where the exchange is being run by the federal government, there will be more of a "cookie cutter" feel, Schuyler said.

But they'll have a few things in common. You'll be able to compare prices for four different levels of health plans: "bronze," "silver," "gold" and, in some states, "platinum," depending on how much of your costs you want the health plan to pay. You'll be able to apply for coverage, and find out how

much of a subsidy you could get to help pay for it, depending on your income. And if you're poor enough to qualify for Medicaid, it should steer you toward that rather than a private health insurance plan.

The trick, for most people, will be to guess how much coverage they'll need. The bronze plan, for example, will have the cheapest premiums, but it will also cover the lowest amount of costs, so it's a better choice for a healthy person than someone who goes to the doctor all the time. It's all based on how much it will cover for an average population: a bronze plan would cover 60 percent of the costs, a silver plan would pay for 70 percent, a gold plan would cover 80 percent, and a platinum plan would pay for 90 percent.

You'll be able to apply for coverage online, but you'll also be able to get help from "navigators" — groups that are getting federal funds to help explain people's health insurance options in the new exchanges. There's a wide range of groups that will be doing the work, everyone from community health centers and hospitals to nonprofits, universities and charities. In some states, there will also be "in-person assisters," individual employees or volunteers of community groups who will help people figure out how to sign up.

WHAT YOU'LL FIND IN A HEALTH EXCHANGE

Some will offer more choices than others, but they'll all give customers the ability to compare health plans and pick one, with subsidies available to reduce the price for people with low incomes. Here's a sampling of plans that will be available in the California health exchange, which will have one of the widest ranges of choices. These examples show the range of prices in each category, from low end to high end.

For a family of four in East Los Angeles, annual income $50,000:

Low	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan
Company	L.A. Care	Health Net	Health Net	Health Net
Total Monthly Premium	$362	$450	$509	$574
Tax Credit	$202	$202	$202	$202
Customer Pays	**$160**	**$248**	**$307**	**$372**
High				
Company	Anthem Multi State Plan	L.A. Care	Anthem Multi State Plan	L.A. Care
Total Monthly Premium	$419	$494	$604	$613
Tax Credit	$202	$202	$202	$202
Customer Pays	**$217**	**$292**	**$402**	**$411**

Source: California exchange premium calculator

You may run into a situation where they'll have to hand you off to a licensed health insurance agent or broker if you want someone to recommend a plan for you — because they've been putting pressure on states not to take that job away from them. In Idaho, for example, you may be able to find an "in-person assister" to explain how all the health insurance options work, but once you ask a question like, "Which plan is best for me," they're going to hand you off to an agent or broker.

What if you can't afford it?

So how do you pay for the coverage? The subsidies are included to cushion the blow of the individual mandate. If the feds are going to require everyone to buy health insurance, the thinking went, they've got to help the low-income people pay for it. And some middle-income people, too, while they're at it.

The catch, of course, is that they're going to drive up federal spending, and right at a time when Democrats and Republicans are butting heads over how to get spending under control. The Congressional Budget Office says the Obamacare subsidies will cost about $1.1 trillion over 10 years.

That's not the whole story, because the budget office also says Obamacare will reduce the overall deficit by putting the brakes on Medicare payments and raising various health-related taxes. But Republicans aren't convinced that the budget office's math is right, especially if the Medicare savings don't all come through — and they point out that the estimate doesn't look beyond 10 years.

Here's how the subsidies work: If your income is low enough, you can apply for a tax credit that will cover a share of the health premiums, with the tax credit getting smaller as your income goes up. It's designed to make sure you don't have to pay more than a certain percent of the premiums for a "benchmark" plan — which is supposed to be the second-cheapest "silver" plan in your area.

The tax credit starts for people earning 133 percent of the federal poverty line — $15,282 for an individual in 2013, $31,322 for a family of four. Anyone at that level would get a tax credit big enough to guarantee that they wouldn't have to pay more than 2 percent of their income for their premiums.

The credit phases out as people earn more money, though. By the time they're earning 400 percent of the federal poverty line — $45,960 for an individual, $92,200 for a family of four

— they'd have to pay 9.5 percent of their income for their premiums. And once they're earning more than 400 percent of the poverty line, there's no subsidy anymore.

To get an idea of how this would work, a family of four in east Los Angeles earning $50,000 a year would have four choices of "silver" plans, and they'd pay between $248 and $292 a month depending on which plan they choose, according to the premium calculator on the California exchange website. The real cost of each plan would range from $450 and $494 a month, but that would be reduced by the premium tax credit, which would be $202 a month.

They'd also be able to get a "bronze" plan for as little as $160 a month — although that wouldn't cover as much of the costs — or a "gold" plan for $307 a month. Or they could splurge on a "platinum" plan for $411 a month.

Expanding Medicaid — or not

The other option, for the people with the lowest incomes, is Medicaid. The original plan under Obamacare was to expand Medicaid to cover everyone up to 133 percent of the federal poverty line — filling in the gaps so the health exchanges could cover the rest. But now, some states are going to take a pass on

expanding Medicaid, leaving those gaps largely unfilled.

The Medicaid expansion was supposed to be mandatory for all states, but the Supreme Court ruled that it had to be optional — that all the federal government could do was offer them incentives to expand. Under pre-Obamacare rules, Medicaid only covered people up to 100 percent of the federal poverty line, and even then, there were gaps within that group. Most adults without kids and some low-income parents were excluded, even if they were very poor.

The goal of Obamacare was to get rid of the holes in coverage, and as an incentive, it offers to cover most of the states' Medicaid bills — paying for 100 percent of the costs for the first three years, and then gradually scaling back to 90 percent of the costs by 2020. But at least 16 states have said no to that deal, and several others are on the fence.

Why would so many states say no to so much federal money? For some, like Texas Gov. Rick Perry and Louisiana Gov. Bobby Jindal, it was the need to keep up a pure anti-Obamacare stance, at least in public (although Perry did quietly try to get some Obamacare funding for a lower-profile health program).

For others, it was the suspicion that no matter what the law

says now, Congress could cut the Medicaid funding down the road and the states would have to pay for the new people. That's why even some Republican governors who wanted to expand Medicaid, such as Florida's Rick Scott, couldn't close the sale with their legislatures.

The Congressional Budget Office has estimated that 3 million fewer people will gain Medicaid coverage now that the states don't have to expand. And a RAND Corporation analysis concluded that those states were shooting themselves in the foot — because the 14 states that led the Medicaid opposition will have to spend an extra $1 billion to reimburse hospitals for medical care for uninsured people.

Some common gripes and misconceptions about the law's implementation — and their level of truthfulness:

What you'll hear: The law is falling apart because everything is being delayed.

Reality check: There have been delays in the rollout of the law, and the one everyone has heard about is the biggest — employers with 50 or more full-time workers won't be penalized for not covering their workers until 2015, a year later

than scheduled. That doesn't prove the law is falling apart because it may not matter much in the long term — but it does suggest that the Obama administration was less than completely ready to implement the law.

The administration delayed two important requirements for employers: the information they're supposed to report on what kind of health insurance they offer their workers (if they offer any), and the penalties for large employers that don't offer what the law considers to be minimum coverage. The delayed penalties also include fines if their coverage is so skimpy that even one of their workers goes into a health exchange instead and gets a subsidy for it.

The official story, when the Treasury Department announced the delay in a blog post, was that the administration wanted time to work with employers to simplify the requirements.

Most experts say the delay won't have a big practical effect — it won't prevent the health exchanges or subsidies from going ahead, and it won't lead to a big increase in the number of uninsured people, since most large employers already offer health coverage.

But the University of Pennsylvania's Mark Pauly and Adam

Leive warned of another danger: if there are no fines for large employers who don't offer coverage, and the exchanges are available as a new source of coverage, some of them could have an incentive to send their workers to the exchanges and make up for the lost benefit by paying them higher wages. That's called "crowd-out," and even though it's only an issue for a year, it's exactly the kind of disruption to people's health coverage that the fines were supposed to prevent.

What you'll hear: There are too many rules in Obamacare exchanges, and that's why so many states took a pass.

Reality check: Republican governors complained that their hands would have been tied by too many rules if they built the exchanges, and some — like New Jersey Gov. Chris Christie — said the administration didn't answer their questions about the costs to their states. The real reason so many states sat on the sidelines, though, is that there wasn't a strong enough reason for them to own the political risks.

If the Obamacare exchanges work well, "you can buy into it a couple of years later. If it blows up, it's not your fault," said Pauly. "The more you negotiate, the more you own it, and most governors decided they didn't want to own it."

The law does set a lot of constraints on exchanges — they all have to offer certain kinds of benefits, they have to provide the standard levels of health plans, and they have to give the kinds of subsidies described in the law, with complicated systems for verifying who's eligible. But there's still room for variation, especially on whether the exchange will be active in seeking only health plans that meet their standards — like California — or just offering information on whatever health plans want to sell the coverage.

And the Department of Health and Human Services did show another kind of flexibility — it postponed deadlines several times and even created a new category of exchanges, the federal-state "partnership," that wasn't even mentioned in the law.

But Brett Graham of Leavitt Partners, the consulting firm, says those moves were mainly intended to prod more states into building exchanges, once it became clear that most of them didn't want to do it.

"They read the tea leaves, and they saw that the states weren't moving. Even blue states weren't moving fast enough," Graham said.

What you'll hear: There will be lots of fraud with the subsidies.

Reality check: Republicans are worried that people will be able to get subsidies by saying they're poorer than they really are. The Obama administration says it will have a good verification system in place, but it also has a fallback: people who get the tax credits are supposed to pay the government back if they weren't eligible for them.

The health exchanges are supposed to check with the IRS and the Social Security Administration to make sure people's income is what they say it is when they apply for coverage. The issue is what happens when the income someone puts on their application is more than 10 percent lower than what those federal agencies show in their records, and the person who's applying for coverage doesn't have a good explanation for it.

At first, it appeared that the exchanges weren't going to have to check those applications in 2014 because they might not have the resources to do it. Now, the Obama administration says the federal exchange will check all of those applications by asking people for more documents. The states won't have to check all of them, though — just a "statistically significant"

sample.

The Congressional Budget Office and the Joint Committee on Taxation, which analyze Obamacare's tax issues for Congress, were OK with that: They wrote in September 2013 that "a program is currently being put in place" that seems to satisfy the law's requirements.

If that's not enough to prevent fraud, there's always a backstop. People who get Obamacare subsidies will report their current income when they file their taxes, and if it doesn't match what they guessed when they applied for coverage, they'll owe taxes to pay back the extra subsidies they got. That provides a built-in incentive for people not to overestimate their income, the Obama administration and its allies say, because no one wants to be hit with a big tax bill.

There's a catch, though: the law limits the amount the government can get back. It can recover anywhere from $600 to $3,500, depending on a person's income, but conservatives worry that some overpayments will be higher than that. So there's a built-in protection against a certain amount of fraud, but it's not foolproof.

IV

How Obamacare Affects Businesses — Large and Small

When Congress was writing Obamacare, its biggest backers said the new law would help small businesses. Instead, they're complaining about it.

It was also supposed to take the cost pressure off businesses in general. Instead, they say it's just adding more pressure.

It's one of the biggest political ironies of the health care law: Some of the loudest gripes are coming from the employers who were meant to benefit from it. But the reality is, from the smallest startups to the largest corporations, employers have a lot of new rules and reporting requirements to keep track of. And in some cases, there are new costs, too.

It's the only way to make the law work — but it's also a head-

ache for many employers.

Obamacare was sold as a way to give small businesses new, cheaper sources of insurance through their own health exchanges. But most of those small-business exchanges won't be able to offer workers a choice of health plans in 2014 — which undermines one of the main purposes of having them. And it's harder for small-business owners to follow the new rules and requirements than it is for bigger businesses, since they don't have big human resources departments to help them out.

"It's very difficult for small-business owners to keep up when the rules of the game keep changing," said Kevin Kuhlman, a lobbyist for the National Federation of Independent Business.

For large employers, Obamacare was sold as a way to rein in those runaway health care costs. But it also created compliance burdens for many employers — new reporting requirements, notices that all employers have to give to their workers and new costs through taxes and fees that help pay for different parts of the law. They're also starting to worry about a big future penalty for especially generous health plans — the so-called Cadillac tax — that could have a far wider impact than the law's authors originally thought.

By the time you factor it all in, business groups say, Obamacare will hurt their costs more than it will help.

"They are adding to employers' costs. So the case can't be made on money," said Helen Darling, president of the National Business Group on Health, which represents large businesses and public-sector employers.

The Obama administration has won praise from employer groups for delaying the requirements for businesses to report the details of their coverage to the federal government, as well as the fines employers with 50 or more full-time workers will have to pay if they don't provide health coverage. But they'll still be an issue for businesses starting in 2015.

Obama administration officials say they're doing their best to get the word out to businesses so they don't run into any nasty surprises. There's a new "health care changes wizard" website to walk all employers through the new requirements. And the Small Business Administration is holding Obamacare events with small-business owners across the country, conducting weekly webinars to teach them about upcoming requirements, and posting news and guides on its website.

"We know folks are busy," an SBA official said — which is why the administration is conducting the educational events

and trying to make the rules easier.

There are loud voices in the business community that depict Obamacare as the biggest threat employers face today — notably the U.S. Chamber of Commerce and the NFIB, two of the most powerful interest groups in Washington.

But there are also employer groups that solidly back the law — like Small Business Majority, an advocacy group that's conducting the webinars with the SBA to tout the law's benefits, like the health exchanges and tax credits for small businesses.

"The benefits far outweigh the costs," said John Arensmeyer, the group's founder and CEO who previously was the founder of an international e-commerce company. "There's been a lot of confusion. ... There's been more heat than light on the subject."

And not all of the alleged dangers to businesses hold up to scrutiny. Is Obamacare a "job killer," as many Republicans charge? Economists say it's just not showing that kind of impact — at least so far. And is it going to cause employers everywhere to slash their workers' benefits? Even UPS, which got national attention for cutting its health coverage for spouses who can get their coverage elsewhere, now says it can't really blame Obamacare for that one.

"I wouldn't characterize it as, 'We did this because of Obamacare,'" UPS spokeswoman Kara Ross told POLITICO — even though its memo to employees was full of references to the law.

Other leading business groups say Obamacare is just part of a bigger picture of rising health care costs that has been going on for years. Yes, they say, employers are trying to find ways to trim their health benefits so their spending rises more slowly. But to pin it all on Obamacare, they say, misses the larger trends in businesses' health care costs.

"Not at all. Everything that's happening now was going to happen anyway, and it's just a matter of how fast and how much," Darling said.

The small-business exchanges

Supporters of the law insist that small-business owners may just not know enough about the law to realize the good things they can get out of it. Case in point: the small-business health exchanges.

They're called "SHOP exchanges," and like the ones for individuals, they're supposed to provide a place to compare health plans and buy them at competitive prices. They'll also

designed to give small businesses with 50 or fewer workers an important advantage: the ability to spread their risk of big medical expenses, since they'll be part of larger groups, and use their combined purchasing power to get better rates from insurers.

And like the health exchanges for individuals, open enrollment for the SHOP exchanges starts on Oct. 1 — although some enrollment is being delayed in the ones run by the feds.

"It's giving small businesses the kind of bargaining clout that big businesses always had," Arensmeyer said. "It creates one-stop shopping for the small-business owner."

There's just one problem: For the first year, employees won't actually have choices in most of the SHOP exchanges.

In all of the ones run by the feds — and remember, these are the ones that are stretched pretty thin — the Obama administration delayed the feature where small-business workers will be able to choose their health plans. So if you're a small-business worker and you live in one of those states in 2014, your employer will just say, "Here's your health plan" — like they do now.

If you live in one of the states that are running their own health exchanges, you're more likely to have a choice of health

plans — most of them will have employee choice in 2014. And you may get that choice in the federally run exchanges starting in 2015, but only if the Obama administration is able to get those marketplaces running more smoothly. The Department of Health and Human Services has a website where you can look up what kind of exchange your state has.

There's also another feature of the law that was supposed to help small businesses: a tax credit to help the smallest ones buy health insurance. It has been around since 2010 on a smaller scale, but starting in 2014, they'll be able to get a credit for up to 50 percent of their health care premium costs if they buy insurance through one of the SHOP exchanges.

It's only for really small businesses, though — those that have fewer than 25 employees (or their "equivalents," again), pay less than $50,000 a year in average wages and pay for at least half of the premiums themselves. And they only get the full credit if they have 10 or fewer full-time workers and their average wages are less than $25,000 a year.

That's why the tax credits haven't gotten a lot of use so far — they just haven't been very helpful to small businesses, and many of the businesses at that level don't offer health coverage anyway (and they wouldn't be required to under Obam-

acare). Kuhlman of the NFIB calls it "underwhelming."

But even if small-business owners aren't sure they would qualify for the credit, Arensmeyer says they should at least talk to their accountant to check it out.

Who has to cover their workers

The issue that most people know about is the "employer mandate" — a loose term for a set of fines for businesses that don't cover their workers. That's a big issue for small businesses that might be right on the edge of 50 workers.

Starting in 2015, any employer with the equivalent of 50 or more full-time workers will have to pay a $2,000 annual fine for each worker — not counting the first 30 — if they don't offer health coverage.

And if they do offer health coverage, it has to meet the law's "affordability test." A worker shouldn't have to pay more than 9.5 percent of his or her income for self-only coverage, and the plan shouldn't cover less than 60 percent of the costs. If the coverage fails either of those tests, the employer will have to pay a $3,000 annual fine for each worker that goes to a health exchange for coverage and gets a subsidy for it.

The catch, though, is that it's not just businesses with 50 ac-

WHAT EMPLOYERS ARE WORRIED ABOUT

These are the provisions of Obamacare that employers consider the most likely to raise their costs, according to an August 2013 survey by the International Foundation of Employee Benefit Plans. The survey included 728 human resources and benefits officers and other industry experts, and respondents could choose up to three reasons.

Top 10 provisions employers say will raise their costs:

1. Patient-Centered Outcomes Research Institute fees: **37.7%**
2. General administrative costs: **35.1%**
3. "Interacting with participants": **27.7%**
4. Reporting/disclosure/notification requirements: **20.1%**
5. Redesigning benefits to avoid Cadillac tax: **18.9%**
6. Preventive care costs: **18.8%**
7. Young adult coverage: **18.5%**
8. Coverage for people who weren't offered insurance before: **17.3%**
9. Eliminating exclusions for pre-existing conditions: **13%**
10. Affordability rules: **12.9%**

Source: International Foundation of Employee Benefit Plans survey

tual full-time workers. It also applies to any business that has the equivalent of 50 full-time workers. In other words, when they add in their part-time or seasonal employees, their hours will add up to at least a few more full-time people.

Who counts as a full-timer? Anyone who worked at least 30 hours. That's one of the biggest complaints restaurants and retailers have about the law — 30 hours just isn't a standard anyone uses. But it's in the law now, and it's leading to the creation of complicated formulas — like the one the National Restaurant Association lays out in its own Obamacare primer — to help businesses figure out whether they meet the 50-worker threshold.

It's a particular problem for the retail and restaurant industries, and that what's leading to all the stories about pizza chains warning that they'll have to charge more for their pizzas. But Neil Trautwein, vice president and employee benefits policy counsel at National Retail Federation, calls the employer penalty issue "a relatively discrete problem for a certain number of smaller employers."

Obama administration officials say 96 percent of businesses in the United States are too small to be hit by the coverage requirements, and of the ones that are big enough to fall under

the mandate, more than 90 percent already offer health coverage.

That doesn't mean businesses won't try to get that 30-hour standard changed, though — some lawmakers have introduced bills to raise the bar to 40 hours a week, and Trautwein says he "could see that issue catching legs." The only problem, though, will be getting even such a small tweak through Congress, since many Republicans don't want to do anything to help Obamacare work better.

New costs for bigger businesses

For larger employers, there are other cost concerns — including direct fees and other costs that will be passed on to them.

For one thing, there's a $63 per person fee starting in 2014 to help cover the costs of "reinsurance" in the health exchanges, or helping to cover the expenses of insurers that get a lot of sick people. The program lasts for three years — 2014 through 2016 — and the fees haven't been set for 2015 or 2016 yet, according to the Society for Human Resource Management.

There's also a fee to support the Patient-Centered Outcomes Research Institute, an organization created by Obam-

acare that's launching research to see what treatments for certain medical conditions work better than others. It's a smaller fee — $2 per person for all health plan years that end after Oct. 1, 2013 — but it lasts longer, until 2019.

And don't forget the taxes that health insurers will be charged each year, starting in 2014, also to help fund Obamacare. The IRS is supposed to send each insurer its estimated fees each year, according to the regulations, but the total fees from all the health insurers are supposed to raise $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018.

Health insurance companies are lobbying to repeal the tax, but you know what they'll do in the meantime? Pass the costs on to employers. It won't hit the largest employers, though, which often insure themselves — just the businesses that get their coverage through insurance companies.

An August 2013 survey by the International Foundation of Employee Benefit Plans found that employers expected their biggest Obamacare costs to be the Patient-Centered Outcomes Research Institute fee, general administrative costs, the expense of explaining Obamacare to workers, the reinsurance fee and the cost of covering workers who didn't have

health insurance before.

Danger ahead: The 'Cadillac tax'

One issue that worries large employers is an Obamacare tax that doesn't kick in until 2018 — but it's a big enough concern that large employers are starting to prepare for it now.

The "Cadillac tax" was put in the law to discourage businesses from providing too much health coverage — because if workers are shielded from too many costs, the thinking went, they'll overuse medical care and not pay any attention to the costs, and health care spending will keep rising too fast. Starting in 2018, there will be a 40 percent tax on insurers — which would be passed on to employers — for any health coverage that goes beyond $10,200 for individuals and $27,500 for families.

It was supposed to be aimed at the most gold-plated of all of the health plans. But now, businesses are worried that by the time it goes into effect, it's going to hit a lot more than just the Cadillac plans.

"You can be driving a Ford and still hit the Cadillac tax," said Sandy Ageloff of Towers Watson, a human resources consulting firm. "That is something that all employers will have to

confront if they continue to offer benefits."

Employers are already planning ahead to try to keep their costs down. In an August 2013 survey, Towers Watson found that more than six out of 10 employers said the fear of triggering the Cadillac tax would influence their health care benefit strategies in 2014 and 2015. The survey covered 420 companies with 8.7 million employees.

For one thing, the thresholds were set in 2010, and even though the law has a method for raising them if there's a lot of growth in health care spending, employers are still concerned that they'll get busted for offering fairly standard plans. And after 2018, businesses don't think the thresholds will rise fast enough. They'll be linked to the increase in the consumer price index, but medical inflation pretty much always rises faster than that.

Think of the Cadillac tax as the slow-moving car in the right lane, chugging along at 45 miles per hour. It may be pretty far in the distance, but if you're an employer and you're moving along at a reasonable clip in the same lane — say, 60 miles per hour — and you don't slow down, you're going to run smack into it.

"What keeps me up at night is thinking about how to man-

age our costs so they stay below the Cadillac tax threshold," said Bruce Elliott, manager of compensation and benefits at the Society for Human Resource Management. "If managers aren't looking at that, they should be."

Keeping up with the reporting rules

All employers are also racing to keep up with their reporting requirements, and the notices they have to give to their workers about Obamacare — which aren't always well-publicized.

Take the notices employers have to give to all of their workers, starting Oct. 1, 2013, to let them know that the new Obamacare health exchanges are available. The notices are supposed to tell workers that they can get health coverage through the exchanges if their employer's health insurance would cost them too much or wouldn't cover enough of their medical expenses. And the notices should tell employees whether the employer already offers coverage that meets Obamacare's standards.

So who has to give out these notices? According to the guidance on the Department of Labor's Obamacare website, it's any business that falls under the Fair Labor Standards Act. That's usually any business that does at least $500,000 a year

in business and has "one or more employees who are engaged in, or produce goods for, interstate commerce."

The requirement didn't get a lot of publicity from the Obama administration, said Kuhlman of the NFIB, because it was a minor provision that got delayed. Then in May 2013, "they said, 'Now we have a better idea of what this should look like, and here it is, and your new deadline is Oct. 1,'" he said.

"I think we had a lot of members who had no idea this was coming, and it's not their fault," Kuhlman said.

The SBA official said the notice has been publicized in its webinars, and employer groups like the National Restaurant Association have been spreading the word, too.

There's also the new summary of benefits and coverage employers have to provide to their workers, which are supposed to compare their health plans in an easy-to-understand grid.

And when employers do start reporting the details of their coverage to the federal government — now scheduled for 2015 — they'll have to prove they're providing health coverage with enough value to avoid the fines and report on who had health coverage so their employees can avoid the individual mandate penalties.

But even if it gets simpler to do that, it will never be totally

simple, according to Trautwein of the National Retail Federation, because there is so much reporting that will have to take place not just between employers and the federal government but between health exchanges and employers. And that increases the odds that some important piece of information will get lost between offices, he says, like when a health exchange checks with an employer to make sure a worker is really eligible for a subsidy.

"It could be a nightmare ... if the notifications from the Wyoming exchange come to corporate headquarters and don't go to the right group if it's a chain restaurant," Trautwein said. "It's inside baseball, but it's not, because it's one of those issues that's going to surprise and shock a lot of people."

Obamacare's impact on businesses is one of the most passionate areas of debate between ACA critics and supporters. Some of the most bitter areas of contention:

What you'll hear: Obamacare is a job killer. And it's creating a new, part-time economy.

Reality check: The "job killer" label is one of the Republicans' favorite terms to describe the law, with "part-time

economy" close behind. They're both meant to describe the bad economic impacts the law could have, as employers either don't hire people — to keep their businesses below 50 workers — or cut their hours to keep workers below 30 hours a week.

The problem is that economists who look at the broad national data just don't see it. At least, not yet.

"It's hard for me to see Obamacare in the employment data," said Mark Zandi, chief economist at Moody's Analytics. "I'm really hard-pressed to find an impact on jobs."

And Mark Pauly of the University of Pennsylvania predicts that "the fraction of jobs that are going to be affected is tiny relative to the overall job market."

Zandi cautions that "the script is still being written," and with the employer mandate delayed until 2015, some of the impact could have been postponed with it — although a lot of businesses were already preparing for the mandate before the delay was announced.

There have been a lot of stories about individual employers cutting back on workers' hours, like adjunct professors and other part-time state employees losing work hours in Virginia. If it's all anecdotal, there certainly are a lot of anecdotes.

But although Zandi says there has been "a bit of a pickup" in

part-time employment, it's not enough to prove a broad trend.

"The anecdotes are very supportive of the idea that we're moving to a part-time economy. The data, at least so far, are not," Zandi said. "Maybe it's the beginning of a trend, and maybe that will become obvious in another year, but it's not obvious at the moment."

What you'll hear: Obamacare means I won't be able to cover my spouse anymore, just like UPS quit covering spouses.

Reality check: There is no widespread move yet to cut spousal benefits completely, according to employer surveys — and even UPS now says it wouldn't pin its decision on Obamacare. But that doesn't mean it's off the table for the future.

It certainly sounded like an Obamacare decision when it was announced. The shipping company is making workers' spouses ineligible for health benefits, starting in 2014, if they can get coverage through their own employer. In its memo to employees, first reported by Kaiser Health News, UPS cited several Obamacare-related costs, including the reinsurance fee, the medical research fee and the likelihood that more workers would sign up for the company's health care plan.

But most economists never really believed that UPS was

really cutting spousal benefits just because of Obamacare — most figured it was something UPS was going to do anyway. And Ross, the UPS spokeswoman, said that's basically right — because the decision was driven by rising health care costs in general, and Obamacare is just part of that trend.

"This is something we constantly look at because health care costs have been rising every year," Ross said.

For now, at least, UPS is an outlier. The Towers Watson survey found that only 7 percent of employers were thinking of cutting spouses' coverage or charging more for it in 2014, when they can get other coverage. Don't rule it out for the future, though: 23 percent said they were thinking about it for 2015 or 2016. And there could be other changes down the road, the survey said, like charging more to cover spouses and all dependents.

The big picture, though, is that more businesses are thinking about changing to high-deductible health plans as a way to shift costs to employees, according to consultants and business groups. The Towers Watson survey found that 40 percent of employers were considering changing the design of their health benefit plans in 2014, and another 31 percent were thinking about it for 2015 and 2016.

"We definitely see them lowering the value of their plans," as well as turning to other cost-cutting measures like using smaller networks of doctors, said Ageloff of Towers Watson.

What you'll hear: Employers are going to stop covering their workers and dump everyone into the health exchanges.

Reality check: That's not in the cards — at least for 2014, because employers don't have a lot of confidence that the health exchanges for individuals will work.

The Towers Watson survey found that only 11 percent of employers were "somewhat confident" that the Obamacare exchanges would provide a workable alternative to their own health coverage while 88 percent weren't confident at all.

They're taking a wait-and-see attitude, though, so there could be a bigger move toward exchanges later if they work. By 2015, though, 24 percent of employers said they were "somewhat confident" and 5 percent said they were "very confident" that the exchanges would be a good alternative.

V

What Doctors May Not Know About Obamacare — and What They Need to Know

Think you can just have your doctor explain Obamacare to you? Good luck with that.

A lot of people will get their information about the health care law from their physicians, figuring they probably understand Obamacare pretty well — because, you know, they're doctors. But the reality, according to physician groups and surveys, is that a lot of doctors are all over the map in their knowledge of the law, and some are falling for the same ideological myths as the general public.

Some have been paying close attention — and their lobbying groups certainly have. And in general, doctors are better informed than the public. But that doesn't mean they know enough to tell you how to sign up for coverage in an Obam-

acare health exchange, or what services are going to be covered, or what to do if you run into trouble.

What's more, it's not clear that many of them understand how it's going to affect them, either.

"As a group, they are incredibly uninformed about a lot of aspects of the law," said Shane Jackson, president and chief operating officer of LocumTenens.com, a physician recruiting firm based in Georgia that has conducted surveys to measure doctors' knowledge. He said the surveys have found that doctors are "not at all prepared" to walk their patients through the main parts of the law, and that there's a "real unfamiliarity" with the changes the law could create in their own medical practices.

If physicians don't even have a clear handle on the changes that will affect them directly — like the payment reforms, which are supposed to pay them for giving better medical care, not just more of it — the Obama administration can't count on them to help explain the law. And that deprives them of some of the best political allies they could have.

For example, one survey in summer 2013 found that more than six out of 10 physicians said they were "not at all familiar" with issues like what the Obamacare health exchange

plans would cover, what the payment rates would be and how the process would work to get their medical claims paid.

Given the level of knowledge, some physician group leaders are worried that their members don't seem curious to learn more.

"We're not hearing a huge amount. That concerns me a bit," said Molly Cooke, president of the American College of Physicians. "The doctors are going to get a lot of questions from patients about how to navigate these new systems. ... I would sort of rather be hearing doctors saying, 'I'm scared of Oct. 1 because I don't know what to tell my patients.'"

The best-case scenario, of course, is that it sends lots of newly insured patients their way. That's the part some physician groups choose to focus on. Jeffrey Cain, president of the American Academy of Family Physicians, says the average family physician sees nine uninsured patients each week — so these would be patients who would now be able to afford laboratory tests, medications and hospital services if they need it.

"We're looking at this as an opportunity for families to have easier access to coverage," said Anne Edwards of the American Academy of Pediatrics.

What worries the docs

But Obamacare will also set in motion big changes in how physicians are paid and how they deliver care. There's not a lot of evidence yet of how well, or how badly, those changes will work — so that leaves lots of room for doctors to fill in the lack of knowledge with their worst fears.

For example, Aaron Carroll, a physician and professor at the Indiana University School of Medicine who gives speeches about the law to physician groups, says the questions he's hearing suggest that some physicians have been influenced by the talking points used by Obamacare's opponents. They ask whether fee-for-service medicine will go away completely, for example, and whether all of their medical decisions will be second-guessed.

That's not going to happen, of course, but those concerns are a clear sign of the anxiety about moving away from the payment system doctors know best — and about where, exactly, the future savings are going to come from.

"Everyone seems to be in favor of less spending, but no one can make less money," Carroll said.

Some of these changes didn't even start with Obamacare. They've already been tested by private insurers and in well-

known, innovative health systems like Geisinger Health System in Pennsylvania. So it's hard for doctors to sort out who's really behind them, or whom to thank — or blame.

That leaves room for a lot of uncertainty about the road ahead. Some of those fears are offbase, fed by misinformation and hype — but there are also issues where they're right to be worried.

How they're getting paid

Most physicians are used to getting paid for how many tests and procedures they give you — which is good for their bottom line, but drives health care spending too high because no one's asking whether all of those services were really necessary. So Obamacare creates new incentives to move away from that system — called "fee for service" payments — and toward payments that reward better, more efficient medical care.

For one thing, there's a pilot program underway to test "bundled payments," in which hospitals and doctors will be paid a fixed amount of money to cover all of their services for treating a sickness or injury. The pilot program is voluntary, and it only applies to Medicare payments. But the fact that it's

in Obamacare sends a clear message: If it's successful, don't be surprised to see bundled payments used more widely around the country — just as they've already been used by Geisinger and private insurers.

The feds are testing different ways of doing this, but one way will be to look at all of the expenses — including the hospital care and whatever services the patient got later, like rehab or home health care — and adjust the payments to fit a target price. Another, riskier way will be to just pay everyone in advance for whatever the feds think the treatment of an illness ought to cost.

There's also a move toward "value-based payments," in which part of the payment is based on how effective the medical care was. It's already happening in hospitals, where they now get rewards for providing good care for expensive services like cardiac care, surgery and treatment of pneumonia. And starting in 2015, Medicare payments to physicians are supposed to be based in part on the quality of their care.

And some physicians will feel the effects of other payment cuts that are hitting hospitals, like penalties if too many patients have to come back too soon for another hospitalization that could have been avoided.

Together, the changes are creating a medley of threatening mood music that is affecting physicians' views of the law.

"I don't think people would object in principle, but there's a lot of uncertainty," said Cooke of the American College of Physicians. After all, she said, there's a long delay between the time a physician treats the patient and the time it's clear whether the patient recovered well. It's easier just to see a lot of patients and make money the old-fashioned way, she said.

"There is no trick at all in saying, 'I saw eight patients between 8 and 11:45,'" Cooke said.

There are other pressures on physicians besides Obamacare, though, and those are adding to the general anxiety. Thanks to a botched payment formula that was added to Medicare in the 1990s, doctors face the threat of double-digit Medicare payment cuts practically every year. Congress always finds the money to postpone it at the last minute, but that just means lawmakers have to go through the exercise all over again the next year — and physicians never live with any certainty about their payments.

But there's also an important issue buried within an obscure set of Obamacare regulations, according to Jackson of Locum-Tenens.com, that could come back to bite some physicians if

newly insured patients haven't paid their premiums.

According to the regulations, the patient gets a three-month grace period before their coverage gets cut off — if they've already gotten their subsidy in advance. But the health insurer only has to pay doctors' claims for one month. They're supposed to warn the doctors if they're about to stop paying the patient's claims, but it could still be a nasty surprise — and 67 percent of the physicians in his survey said they didn't know anything about how the grace periods work.

"That's a potentially very serious problem," Jackson said.

Hitting the hospitals

There's another set of Obamacare payment penalties and outright cuts that are aimed at the hospitals, and they'll become big issues too — not just for the hospitals, but for the physicians who work with them.

When Obamacare passed Congress, the hospitals agreed to accept $155 billion in payment cuts over 10 years, in return for all of those newly insured patients the law would send their way. It seemed like a reasonable tradeoff at the time, because if hospitals didn't have to shell out as much money to treat uninsured patients, they could afford some cuts in other plac-

es.

That's no longer looking like a safe bet, thanks to the states that have decided not to expand Medicaid — a decision that means hospitals in those states can no longer count on as big a reduction in the number of uninsured patients. And yet, they're still facing the federal payment cuts.

Part of the $155 billion comes from a reduction in "disproportionate share hospital" payments, which go to hospitals that treat a large share of uninsured people. The lower payments "were predicated on the idea that we would have expanded coverage," said Rick Pollack, a top lobbyist at the American Hospital Association. That's one reason the hospital group has been pushing those states to reconsider their decisions not to expand Medicaid — they'll be under even more financial stress if they don't get more patients who can pay their bills.

But other cuts will come from Obamacare policies that are supposed to encourage hospitals to be more efficient, and to make sure their patients don't end up back in the hospitals because they didn't heal correctly.

One big source of future cuts is the readmission penalties, which are supposed to cut the payments to hospitals that have

too many patients return within 30 days after they've been treated for heart attacks, heart failure or pneumonia. Those penalties apply to patients who have been discharged from those hospitals after Oct. 1, 2012.

There's also a round of Medicare payment cuts that will hit hospitals in the form of "productivity adjustments" — meaning, as you can guess, that they're supposed to learn to do more with less money. Their Medicare payments will increase more slowly over the next 10 years, and the same will happen to nursing homes, home health care, rehabilitation facilities and other health care providers. But it's the hospitals that will really sweat it out, since they're already facing the other cuts.

Those cuts won't hit physicians directly, but any doctors with admitting privileges at those hospitals will see indirect effects, because they'll have to comply with tougher hospital policies to make sure there's better coordination with the care the patients get after they leave the hospital, according to Dean Rosen, a health care lobbyist and former Senate Republican aide.

There also could be more pressure down the road. Since the passage of Obamacare, Pollack said, hospitals have had to absorb another $95 billion in other, separate cuts passed by

Congress — including the fiscal cliff deal at the end of 2012 and other trims to help pay for the delays in those Medicare payment cuts to doctors. That's on top of the $155 billion they're already facing in Obamacare cuts.

All of that uncertainty affects physicians too, so it's no wonder that physicians are nervous about what else lies ahead if the payment system is changed.

Cooke says value-based payments are "in their infancy," so it's impossible to know if they'll work well, or even if they're being measured in the right way.

But she said other ways of measuring the quality of care have backfired. For example, hospitals used to be urged to give patients antibiotics within four hours if they seemed to have pneumonia — but that standard has been relaxed after the medical community realized it was just leading to overuse of antibiotics, which can lead to the rise of infections that can't be treated with those medications.

"I think we've seen already a fair number of metrics that have had consequences," Cooke said.

How they're delivering care

There's also a fair amount of physician stress over the new

ideas, encouraged by Obamacare, about how to reorganize your medical care so you don't have a bunch of doctors who never talk to each other. The trends were already heading toward these new kinds of medical organizations, but Obamacare is putting money behind them — and physicians don't want to get left behind.

One of the biggest new ideas is "accountable care organizations," a name that makes it sound more complicated than it really is. They're basically networks of hospitals and physicians, or networks of different kinds of physicians, that work together to save money by giving more efficient medical care to their patients. They're supposed to share the money they save, but under some of the riskier models that are likely in the future, they'll also have to eat their losses.

The Obama administration is staking a lot on the growth of these networks, because the hope is that they'll help trim Medicare spending in the long run. More than 250 networks are participating in the Obamacare program, and the administration says the early models — called "Pioneer Accountable Care Organizations" — managed to squeeze out some small savings in 2012. Not big savings, but enough that they could grow in future years.

Some are doing it by making sure fewer patients are readmitted to the hospitals, or by helping patients control their blood pressure. Others are trying things like sending nurses to patients' homes to help them with their medications, or with their blood-sugar readings if they have diabetes.

What worries some physicians, though, is that they'll have to get into the accountable care organization business because that's the direction the medical world is heading — and it's not easy for all of them to do that.

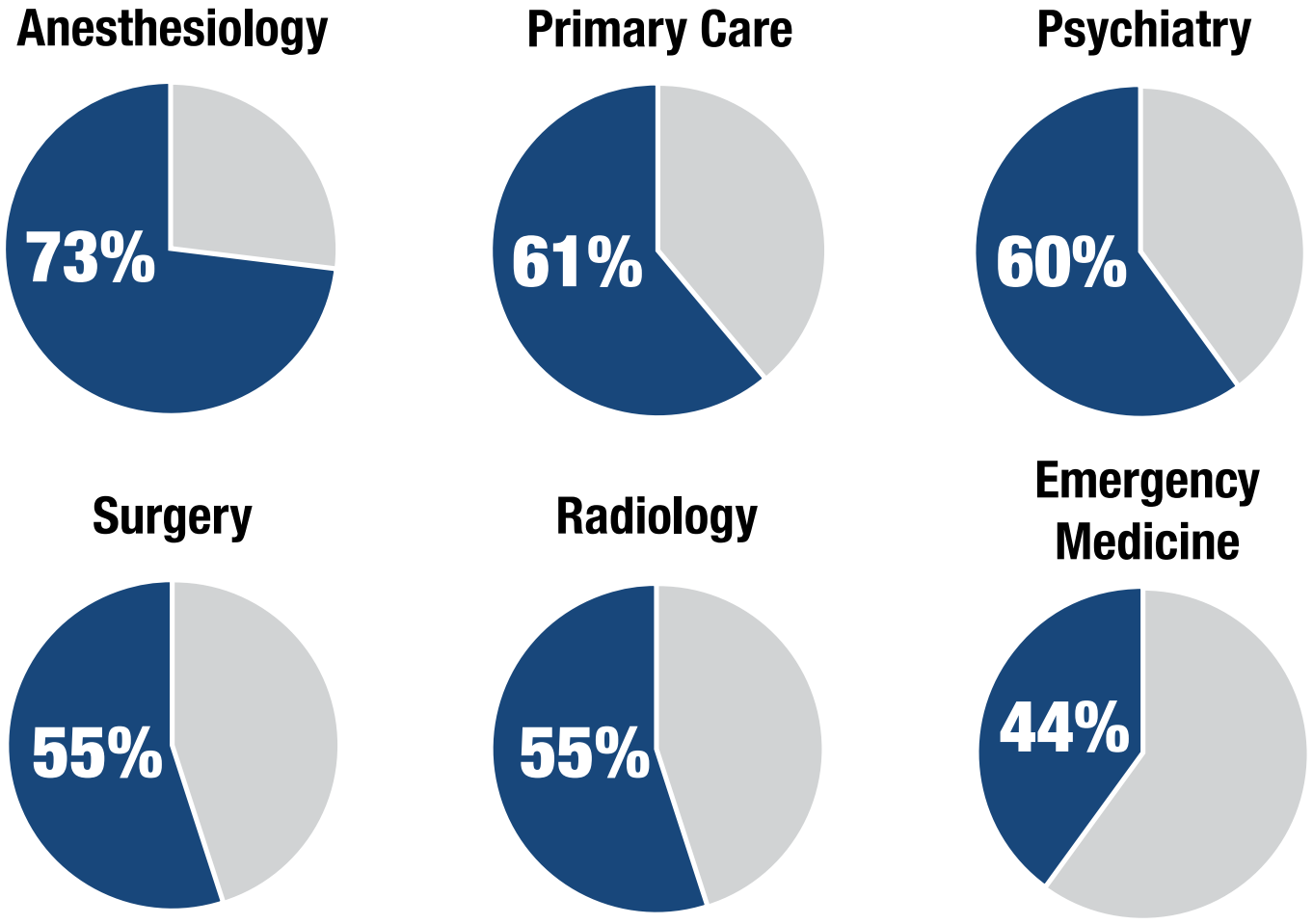
"There's a fair amount of apprehension from physicians in small groups that it's not going to be a game they can play," said Cooke — especially if they work in rural areas without big health care systems to latch onto.

Eugene Sherman, a Colorado-based cardiologist who's one of the leaders of the American College of Cardiology, says it's also not clear how specialists will fit into these networks, mostly because of the lack of experience with them. "It's not that we have any experience or distrust of these models — they're just too new for us to say anything," he said.

There's some distrust in the emergency rooms, though. Another LocumTenens.com survey found that emergency room physicians are the least likely to be interested in being in an

WHAT PHYSICIANS THINK OF ACCOUNTABLE CARE ORGANIZATIONS

Emergency medicine specialists are less willing to participate in accountable care organizations than other physicians, according to a February 2013 survey of 1,416 health care providers by LocumTenens.com. Here is a listing of who's willing to take part in these new arrangements, by specialty:



Source: LocumTenens.com survey

accountable care organization, in part because, as one put it, it's "very hard to determine risk reduction and appropriate care" under the pressures they face. Overall, the survey found that 60 percent of physicians were willing to be part of these

networks, but 40 percent had no interest in them.

Some of the claims and counter-claims about how Obamacare will affect physicians:

What you'll hear: Obamacare means government is getting between you and your doctor.

Reality check: It's one of the most popular sound bites in the Obamacare debate, but it doesn't hold up to scrutiny. Yes, the law is encouraging these new ways of delivering and paying for health care, but the medical community was already talking about most of them — and experimenting with them — before the law ever came along.

And even though the law is testing out the new payment incentives in the Medicare program, it still doesn't touch the payments doctors will get from private health insurers. That could change down the road if the experiments are successful. But for now, they're still very much based on "fee for service," where they get paid for the amount of medical care they give you.

"There's nothing in the law that gets rid of fee for service. There's nothing in the law that changes how private insur-

ance reimburses at all," said Carroll. "There's nothing — and I mean nothing — about getting authorization for treatments or choosing therapies at all."

What you'll hear: There won't be enough primary care doctors to take care of all the newly insured people.

Reality check: That could be a problem, all right. They're working on it, but it'll take a while.

If there aren't enough primary care doctors throughout the country, those newly insured people won't have any place to go — or they'll make the waiting room lines longer for everyone else. So yes, Obamacare is going to increase the pressure to add more primary care doctors to the workforce. That said, it's not the biggest reason the country will need more doctors, medical groups say. It's only the No. 3 reason.

A 2012 study in the Annals of Family Medicine — a journal published by seven family physician groups — predicts that the nation will need another 52,000 primary care doctors by 2025 to keep up with the demand for services. But the biggest reason for that need, the study said, is population growth. That accounts for the need for 33,000 primary care physicians, while the growing number of elderly patients will re-

quire another 10,000 doctors.

The Obamacare insurance expansion, according to the study, means there will have to be another 8,000 primary care doctors in the mix.

It's not easy to get newly minted doctors to go into primary care — the pay isn't as good as it is for specialists, and that can be a real issue when they graduate with staggering medical debt. Obamacare tries to deal with that issue by boosting funding to train new primary care doctors. There's also a 10 percent bonus Medicare payment for primary care services that's available through the end of 2015.

And the law has a temporary pay hike for Medicaid — paying primary care physicians the same amount that they'd get under Medicare — but it only lasts until the end of 2014. Some states are also allowing nurses with advanced training and physicians' assistants to do more, but there are a lot of turf battles with physicians that are slowing that down.

Those measures may help a bit, health care experts say, but they won't solve the long-term problems. And those will be a constant source of attention, since primary care doctors will always be needed — especially in the new world of accountable care organizations and other new ways of delivering

medical care.

It's not just the primary care doctors that will be in need, though. There will always be areas of the country that don't have enough specialists — and it could become harder to recruit them in states that decided not to expand Medicaid, according to Sherman of the American College of Cardiology. That's because those states will have more uninsured people, and specialists who perform time-consuming services — like cardiologists — would naturally rather live in states where more patients have insurance.

"Will Mississippi and Texas be at a big disadvantage over the next few years in recruiting cardio specialists? We don't know for sure, but it makes sense that they would be," Sherman said.

VI

Beware of the Obamacare Talking Points

Still hearing Obamacare talking points that sound suspicious? Of course you are. They're popping up all the time.

And no matter what happens with the law in the coming years, you're going to keep hearing new ones. Because the battle lines are drawn — and no one is ready to just let it go.

At this point, it wouldn't matter if Obamacare was a complete success or a complete failure, but that's unlikely anyway. There will be plenty of successes for President Barack Obama and the Democrats to point to — because people will get health insurance who couldn't get it before.

But the launch has been bumpy enough, with delays and political breakdowns in the states, that more failures and break-

downs are inevitable. And when those happen, Republicans and other conservatives will jump all over every one of them.

For now, here's how to judge some of the most common rhetoric from both sides that you're likely to hear — and cut through the best-case and worst-case scenarios to figure out how the law might actually work.

What you'll hear: Obamacare is a new entitlement, just when we can't afford any new entitlements.

Reality check: It's the centerpiece of Republicans' arguments for defunding Obamacare: Once you've created a new entitlement, there's no way to shut it down. There are differences between Obamacare's subsidies and fully government-run social programs like Social Security and Medicare — but the reality is, yes, they're an enormous new expense that will continue as long as Obamacare survives.

Technically, Obamacare's subsidies are tax credits. Like the child tax credit or the earned income tax credit, they'll go to anyone who qualifies. But unlike Social Security or Medicare, they don't provide the benefits directly — they help pay for private insurance companies to do that.

No doubt about it, though — they're going to cost a lot of

money. According to the Congressional Budget Office, the tax credits are expected to cost about $1.1 trillion over 10 years.

And when you throw in the cost of the Medicaid expansion — which builds on an existing entitlement program — that adds $710 billion over 10 years. (That's before you count the Medicare savings, health-related taxes, and other measures that are supposed to offset the costs.)

So does that make the Obamacare subsidies a new entitlement? It depends what you think that word means. If the main test of an entitlement is that the spending automatically continues every year, then yes, it's an entitlement, according to health economist Mark Pauly of the University of Pennsylvania.

"It is an entitlement in the sense that it's on automatic pilot," Pauly said. "It's more like Medicaid or welfare than it is like a temporary tax credit to stimulate the economy."

It's true that the Obamacare subsidies aren't temporary — they'll keep on going as long as the law exists. But officially, they're still tax credits, so they work like any other credit in the tax code, according to Larry Levitt of the Kaiser Family Foundation.

There are also mechanisms built into the tax credits to keep

the federal costs from increasing too much as the health insurance premiums rise — unlike entitlement programs, where the spending is completely automatic, Levitt said.

There's also one big difference between this and the big entitlements, Pauly said: Congress can easily scale it back, given all the political turmoil that surrounds it. He doesn't buy the argument that it's untouchable.

"It's not the kind of entitlement I'd hang my hat on," Pauly said.

What you'll hear: Obamacare is already helping to slow down the growth of health care spending.

Reality check: The Obama administration is trying to make the case that the law is bringing costs under control. There's just one problem: The actuaries in the agency that runs Medicare don't see it that way. In fact, they say health care spending is about to speed up under Obamacare, not slow down.

There's no denying that the pace of the nation's health care spending is slower than it used to be. Since 2010, it has grown at an average rate of 4 percent a year, after a decade in which the growth was closer to 7 percent a year, according to a September analysis by the Medicare actuaries.

And a Kaiser Family Foundation survey of employer premiums in August found that they're growing more slowly too — just 4 percent in 2013.

The administration is careful never to say that's entirely because of Obamacare. But Obama himself has said that the health care law is at least part of the reason — and he's using the slower spending growth to help make the case for the law.

"Thanks in part to the Affordable Care Act, also known as Obamacare, the cost of health care is now growing at the slowest rate in 50 years," Obama said in a September speech to the Export Council. "It turns out actually a lot of what we've done is starting to bear real fruit, and it has an impact on the bottom lines of American businesses as well as the American people."

It's not clear how much, if any, of the slowdown in spending is really due to Obamacare. The Medicare actuaries say it's probably because of the recession and slow recovery, which is forcing people to be more careful about how much medical care they use, and because employers are shifting to health care plans that make their workers pay more of the costs.

But Obamacare probably has played some role. Medicare spending has slowed down — growing just 4.6 percent in 2012,

compared to 6.2 percent in 2011 — and the actuaries say that's partly because of the cuts in payments to health care providers.

And David Cutler, a health economist at Harvard University, says Obamacare's incentives to pay doctors for providing better medical care, rather than just more of it, are helping to bring down costs. There are also other factors that have nothing to do with the law — like slower growth in the use of medical technology — but "it would be a mistake to dismiss the [Affordable Care Act] entirely," he said.

The problem for the White House, though, is that the actuaries also say health care spending will start taking off again in 2014 — and Obamacare is a big part of the reason.

"In 2014 the implementation of provisions of the Affordable Care Act related to major coverage expansions is expected to accelerate health spending growth to 6.1 percent," the actuaries wrote. That's because, as people get health insurance for the first time or gain better coverage with lower out-of-pocket expenses, they'll use more medical care.

That trend will continue in later years, because health care spending will be kept high by an improving economy that allows people to keep spending money on medical care, the ac-

tuaries said.

Administration officials say they won't respond to predictions. Instead, they prefer to focus on what the law has already done. They insist the payment incentives have had an impact, and that the law has also kept health insurance premiums down through another Obamacare provision that requires insurers to give public explanations for any rate hikes of 10 percent or more.

The bottom line: The Obama administration has some support for its claims that the law has helped to control costs, but there are also plenty of other factors. And if the Medicare actuaries are right, and health care cost growth starts speeding up because of the expansion of coverage, none of the other Obamacare provisions will get much credit from the public anyway.

What you'll hear: Don't worry, the subsidies will make health insurance affordable for most people.

Reality check: That's the usual comeback Obamacare supporters use against the threats of "rate shock" from rising premiums. But that's not the end of people's worries about their health care costs — and anyone who expects Obamacare to

solve the problem will be in for a rude awakening.

Because people won't just pay attention to what they have to pay in premiums in the health exchanges — they're going to worry about their out-of-pocket costs, too. And once you factor those in, there will still be people who struggle to pay for their health care costs.

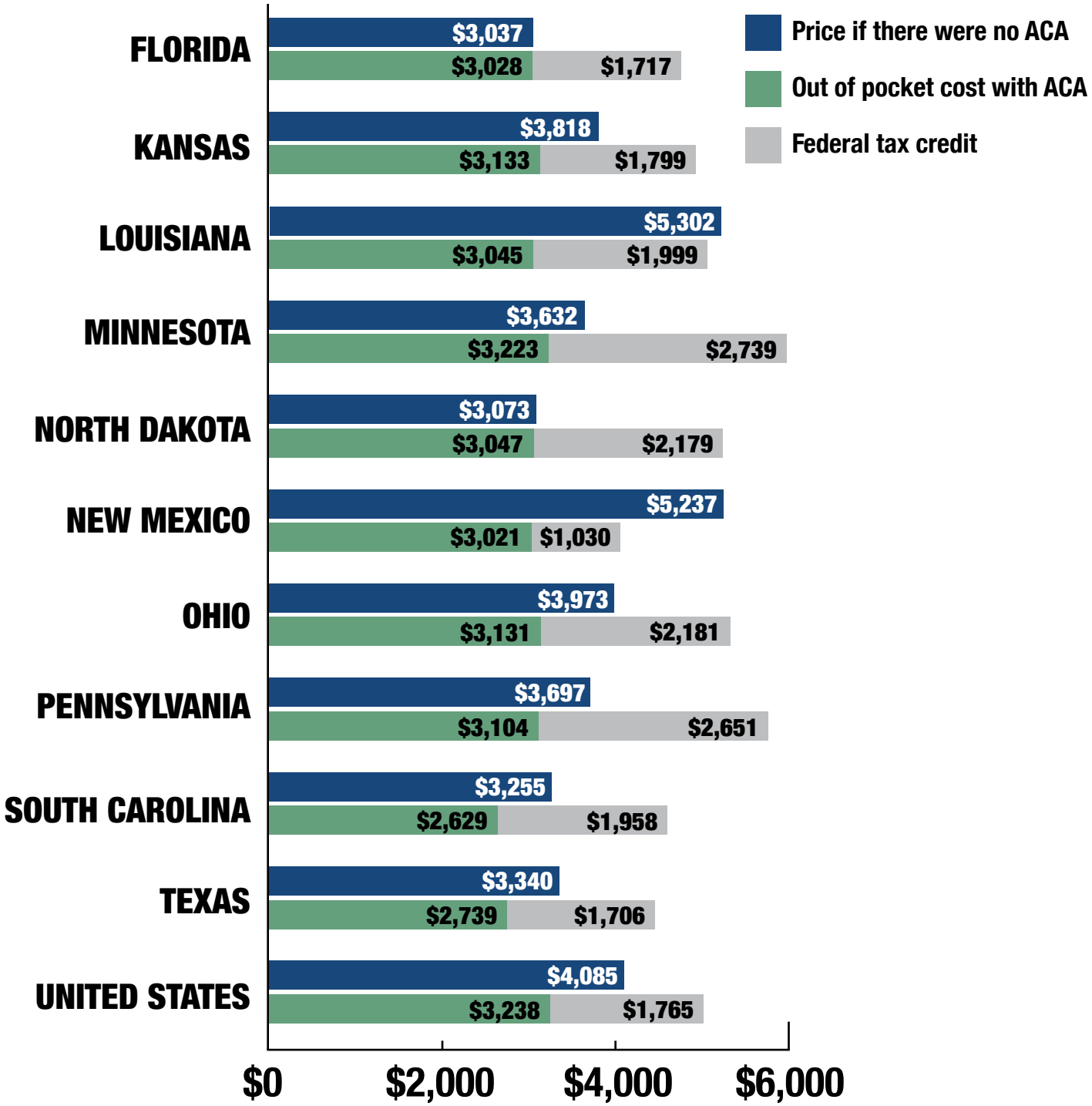
There's also a separate issue that has health care advocates up in arms: If workers can get what's considered "affordable" health coverage for themselves through their employer, their families can't get Obamacare subsidies at all. And the workplace coverage only has to be considered "affordable" to the employee — not to the family members.

The premiums in the health exchanges are lower than predicted when Obamacare was signed into law, although they'll vary a lot across the country, according to an analysis by the Kaiser Family Foundation. A single 25-year-old earning 250 percent of the federal poverty line — $28,725 per year — can get a "silver" plan for $193 a month in most cities after the tax credits are added in, or a "bronze" plan for as little as $111 a month in New York City after the tax credits, the analysis found.

And a single 40-year-old at the same income level could get

HOW AFFORDABLE WILL THE COVERAGE BE?

A RAND Corporation estimate of health insurance premiums for 10 states in 2016 found that the "sticker price" will rise in most states, but once the subsidies are factored in, people will pay less in most states.



Source: RAND Corporation analysis, August 2013

a “bronze” plan for anywhere from $97 a month in Hartford, Conn., to $168 a month in Sioux Falls, S.D., after factoring in the tax credits, according to the report.

That’s not the end of the story, though. People still have to pay other expenses on their own, like co-payments for doctors visits or prescription drugs, and deductibles, the fixed amount of money they have to spend beyond that before the coverage kicks in.

Obamacare does put limits on those out-of-pocket expenses for the first time, but they’re pretty high. All together, people with a lot of medical expenses might still have to spend as much as $6,350 a year out of pocket for their own health care, or $12,700 a year for a family’s expenses.

And even those limits have been delayed — the Obama administration is giving some group health plans until 2015 to comply, because they said they needed more time based on the way their health benefits are structured.

Obamacare does include another set of subsidies for low-income people to help keep those out-of-pocket expenses from rising that high. For example, these cost-sharing subsidies are supposed to keep the expenses down to $2,250 for individuals, and $4,500 for families, for people with incomes below

200 percent of the federal poverty line.

But an analysis by Jonathan Gruber of MIT — who consulted on both Obamacare and the Massachusetts health reform law — found that those limits are still too high to keep a lot of low-income people from facing medical bills they can't afford, if they're sick enough to need a lot of medical care.

"I think there is going to be an issue for sick guys between 150 percent and 300 percent" of the federal poverty line, said Gruber.

For the most part, though, the subsidies should be generous enough that most people will be able to afford the health insurance that Obamacare will require them to buy, Gruber said.

"They may not be happy about it. Affordable and happy are two different things," said Gruber. "But the question is, will they be able to get this insurance without changing their standard of living? And the answer is, yes."

What you'll hear: It'll be just like shopping for a flat-screen TV or a car.

Reality check: It may get there, but it will take a while. For now, if you don't speak health care, be prepared for one con-

fusing ride.

Obama used to say the new health exchanges would let you compare and buy health plans just as easily as you might buy a plane ticket on Expedia. Lately, he's been using a different comparison: buying flat-screen TVs online.

"The good news is that starting Oct. 1, new online marketplaces will allow consumers to go online and compare private health care insurance plans just like you'd compare over the Internet the best deal on flat-screen TVs, or cars, or any other product that is important to your lives," Obama said at his July 18 health care event at the White House.

The flat-screen TV comparison is actually the best one to use, according to Dan Schuyler, the director of exchange technology at Leavitt Partners — but only because buying flat-screen TVs online can be confusing as hell.

Buying airline tickets online is actually fairly simple, Schuyler said, and even buying a car is manageable when people know what they're looking for. But when you try to buy a flat-screen TV, he said, you're overwhelmed with dozens of different models and so many technical details — what's the resolution, what kind of ports does it have, what's the screen refresh rate — that it becomes impossible for a lay consumer to sort

out the differences.

And that's what's in store for people who have never had health insurance. "They won't know what a premium is, or what a co-payment is, or what a benefit design is," Schuyler said. "They're going to be inundated with a bunch of different plans and a lot of terms they're not familiar with."

For people with more savvy in dealing with health insurance, though, exchanges will be an improvement over what they can use now, according to Levitt of the Kaiser Family Foundation. The price that's quoted to them is likely to be closer to what they'll actually pay. That's because they'll no longer have to fill out lengthy medical questionnaires to find out what their actual price is.

It won't be quite the same as buying a flat-screen TV, but "it'll be easier than it is now," Levitt said.

Schuyler said the exchanges will be more like Travelocity eventually — but not in the beginning, when some exchanges will be struggling to perfect some of the search tools they ultimately should have, like allowing customers to search to see if a health plan covers a particular drug they need.

So yes, Obama's comparisons may be right — but not necessarily for the reasons he had in mind.

What you'll hear: You won't have enough doctors to choose from.

Reality check: Some health insurers are keeping their prices low in the Obamacare exchanges by reducing the number of doctors and hospitals in their networks. That could mean you won't have as many choices as other people – but you'll still have choices, and there should be ways to check a health plan's network to make sure it has the doctors you need.

The decision to use narrower networks has gotten national attention in the Los Angeles Times and the New York Times, and Republicans have jumped on the reports as proof that people won't be able to keep their doctors under Obamacare.

That could be an issue for people who used to have other health insurance and then move to an Obamacare exchange – say, because their employer stops offering health coverage and sends them to the exchange, where the plans don't cover as many doctors and hospitals as their old insurance.

But for the main customers — uninsured people — having access to some doctors will still be better than having no doctors at all. That's why some consumer advocates and health experts say they're just not that worried.

"The issue isn't narrow networks. The issue is timely access

to care," said Anthony Wright, executive director of Health Access, an advocacy group in California, one of the states that has gotten attention for the smaller networks. "As long as you can get in to see the doctor you need, you don't care whether it's a narrow network or a broad network."

Larry Hicks, a spokesman for the California health exchange, acknowledged that officials accepted the smaller doctor networks as "part of a tradeoff in the negotiations with the insurers in order to keep the premiums low." The exchange officials will keep an eye on things to make sure newly insured people aren't blocked from getting the care they need, Hicks said – but the bottom line is that the exchange still "opens a whole new world of services to previously uninsured people."

And in California, at least, the exchange will allow people to search the networks of each plan before they sign up, to make sure their doctor is in it or the hospital closest to their neighborhood is covered. "The exchanges are not the problem — they can be the solution," Wright said.

It's not clear that every exchange will have that kind of search capability when they first open. And newly insured consumers could run into problems if they accidentally go out of the network — say, to a hospital that isn't covered — and

face higher charges because of it.

But that can already happen under other health plans, which is why people are always advised to check their insurer's website to make sure a doctor or hospital is covered.

And the reality, health experts say, is that the exchanges and insurers really didn't have a choice. Narrower provider networks are an obvious way to keep costs down, they say, and it was either this or have higher prices for Obamacare coverage.

"Narrow networks are why we don't have rate shock," said health care consultant Robert Laszewski.

And narrower networks could become a reality beyond Obamacare anyway. Even employers are starting to explore the strategy to keep their own costs down, although not in the same way that the Obamacare exchanges are doing it.

The approach that's being tried by some employers is to provide a higher level of benefits if people use "high-performance networks" — doctors and hospitals that have a proven track record of good outcomes. The employees can still use the regular doctor networks at a lower level of benefits, and then they have the highest out-of-pocket costs if they go outside the network, according to Sandy Ageloff of the human resources consulting firm Towers Watson.

"There is definitely enough evidence to say that it's a growing trend" to steer employees toward smaller networks of doctors and hospitals, Ageloff said — just "not as quickly and not as dramatically" as the Obamacare health exchanges are doing it.

What you'll hear: Obamacare will reduce the deficit, because those Medicare spending cuts will help pay for the law.

Reality check: The Congressional Budget Office has always said that the law pays for itself, at least for the first 10 years, in part because of the Medicare cuts. But that assumes the payment cuts will actually be carried out — and the actuaries in charge of the Medicare program think they're unrealistic and won't survive.

The payment cuts to health care providers are supposed to cut Medicare spending by $415 billion over 10 years, according to the most recent CBO estimates — a big source of savings that can help offset the extra spending on Obamacare subsidies and the Medicaid expansion. At least, it would help pay for Obamacare if the savings actually happened.

But the Medicare actuary's office has been skeptical all along. In a May 2013 memo, the office said there was a "strong

likelihood that the [payment changes] will not be sustainable in the long range" and that Congress would have to override them "to ensure that Medicare beneficiaries continue to have access to health care services."

Rick Pollack of the American Hospital Association said the cuts have already been factored into the annual payments that are set for hospitals, so it's hard to tell how much of an impact they've had so far. They're mixed in with the other cuts the hospitals have had to swallow, he said. But Pollack says most hospitals are already paid less than their actual costs for treating Medicare and Medicaid patients — so "we're really concerned" about what will happen over the long run if the latest reductions stay in place.

What you'll hear: The "rationing board" is going to get between you and your doctor.

Reality check: That's the Republicans' name for the Independent Payment Advisory Board, a panel created by Obamacare to recommend new ways to put the brakes on Medicare spending if it grows too fast. Paul Ryan made the term famous on the campaign trail with Mitt Romney in 2012.

There's just one catch: It doesn't exist yet. And the way

things are going, it may not exist for years, if ever.

For one thing, the panel of experts is only needed if Medicare spending grows beyond certain target rates. Lately, though, Medicare spending has actually been lower than expected. So in April 2013, the actuaries at the Centers for Medicare and Medicaid Services, which runs the Medicare program, announced that there was no need for the board to find any spending cuts for 2015, the first year they might have been needed.

That's just as well, because Obama hasn't even nominated anyone to the 15-member board yet. If he did, he could expect Senate Republicans to block just about anyone he picked, and the chances that Democrats could round up enough votes to break a filibuster are pretty close to zero.

The law says the board would be specifically banned from rationing health care, but Republicans say the practical effect of its cuts would be to hurt seniors' access to needed medical care. Congress would have to take up its recommendations under special "fast track" procedures, and it wouldn't be able to change the cuts unless it could come up with another way to save the same amount of money.

Even if the board ever did get named, it has other con-

straints on its power. The law prevents it from recommending any cuts to hospitals, since they already agreed to $155 billion in Obamacare payment cuts and insisted they should be protected from any more. The board also has to keep its hands off of long-term care hospitals, hospices, and psychiatric facilities.

So any of its cuts would have to be concentrated in a few areas, like private Medicare Advantage plans, Medicare prescription drug coverage, nursing homes, home health, and ambulatory surgical centers.

Right now, though, it's all hypothetical. If Medicare spending starts growing faster again, Obama might have to nominate some board members and take the political hits. Until that happens, though, he has no reason to pick yet another Obamacare fight with Congress.