

National Health Reform: Celebrate!! and Continue the Fight

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League of Women Voters of Alameda March 25, 2010

I. WHERE ARE WE NOW?

Unprecedented progress, yet barely won:

Comprehensive legislation passed by both Houses: historic!

Unprecedented effort, major compromises, yet bills barely passed.

January 15 House/Senate leaders reached agreement for CBO scoring

January 19, MA election: loss of Senate filibuster-proof super-majority.

“Resurrecting” the bill: a monumental accomplishment

Progressives regrouping:

In Congress: campaign for the public option;²

In national advocacy campaigns.³

New focus: use Reconciliation to fix the Senate bill and pass it.

Leadership commitment: Obama and Pelosi⁴

February 22: Obama proposal released.

February 25: White House Summit

March 21 House passes two bills!

The Senate bill, HR 3590. The Patient Protection and Affordable Care Act (PPACA). 219—212. Signed by President 3/23/10!

The reconciliation bill: HR 4872, The Health Care & Education Affordability Reconciliation Act of 2010.

March 25: Senate passes the House reconciliation bill!! 56--43

Democratic strategy: no amendments, avoid further House votes⁵

What’s next? intense struggle to protect gains, desperate need to regain civility

II. WHAT HAPPENS WITHOUT REFORM? Why the status quo is intolerable

More people will die due to lack of insurance;

2008: 45.7 million uninsured;⁶

2019: 54 to 66 million uninsured.⁷

Employer coverage unraveling:⁸

Individual/small group insurance unaffordable or unavailable⁹

22,000—45,000 deaths per year.¹⁰

Coverage will continue to deteriorate: more people forced into higher cost-sharing¹¹

Health costs will continue to skyrocket:

Premium increases outpacing wages and inflation: 1999-2008

Premiums: **131%**; Wages: **38%**; Inflation: **28%**.¹²

Medicare insolvent in 2017.¹³

Federal deficits intractable.¹⁴

III. THE NATIONAL HEALTH REFORM BILL: A FRAMEWORK FOR THE FUTURE¹⁵

“ENSHRINING” THE CORE PRINCIPLES OF A JUST HEALTH CARE SYSTEM¹⁶

- Everyone deserves access to comprehensive and affordable health coverage.
- The share of income that people spend on health care must be limited.
- Health insurance must provide coverage for sick people, not discriminate against them.
- Everyone must contribute to financing.

CREATING NEW INSTITUTIONS TO *BEGIN* TO IMPLEMENT THESE PRINCIPLES, ESTABLISHING THE FOUNDATION FOR ONGOING REFORMS

(1) To provide access to coverage: everyone¹⁷ will have access to one of three sources:

- **Employer coverage:** must meet minimum standards of coverage and affordability;
- **Public coverage:** with Medicaid eligibility increased to 133% of FPL for all adults (\$14,404 individual; \$29,327, family of four)
- **New insurance Exchanges:**
To offer regulated plans to everyone without alternative coverage and to small employers (up to 100 employees; expansion to larger permitted). Must include one multi-state non-profit offered by OPM.¹⁸
Members of Congress required to purchase plans in the Exchange.

Insurance reforms to end denials and discrimination:

- Guaranteed coverage and renewal;
- No exclusion of pre-existing conditions, no rescissions;
- No consideration of gender or health status in premium rating.

(2) To ensure good coverage:

A new essential benefits standard requiring comprehensive services and limits on cost-sharing (co-pays, deductibles, etc). No copays for preventive care. Out of pocket maximums: \$5950 for individuals; \$11,900 for families (Only 8-16% of those subsidized in Exchanges expected to reach limits.¹⁹)

(3) To increase affordability:

Income-linked subsidies to purchase plans in the Exchanges:

Subsidies for people **up to 400% FPL (\$88,000 family of four)**, to limit the percent of income spent on both premiums and out of pocket costs, from **2% -- 9.5%** of income.

Subsidies for employees whose employer coverage is not affordable or adequate²⁰

Insurance regulation to lower premiums and cost-sharing:

- Limits on cost-sharing
- No annual or lifetime caps on coverage;
- Limits on administrative overhead and profits (80-85% MLRs)²¹
- Annual justification of premium increases required for all plans;
- Plans with excessive premium increases may be excluded from Exchanges.

(4) To provide fair financing:

Employer requirement to meet minimum standards of coverage and affordability or contribute to costs of subsidies;

Small business exemptions/support: businesses < 50 employees exempt; tax credits for < 25 employees and < \$50,000 average annual wages;

Individual requirement to obtain coverage unless exceeds 8% income;²²

New taxes to help raise the revenues necessary to finance reform.

(5) To limit costs and help ensure long-term affordability:

Price limits:

In Medicare (which often sets trend for private insurers)

- Reduced increase in Medicare reimbursement rates;
- Reduced subsidies to Medicare Advantage plans;
- Independent Payment Advisory Board: to develop measures to enforce a cap on Medicare spending, with limits on Congress' authority to amend or overturn.²³ Measures cannot reduce benefits or increase premiums.

For all insurance plans: listed above

Payment and delivery system reforms to increase quality and cost-effectiveness:²⁴

Comparative effectiveness research, increased payment for primary care, care coordination, team efforts; reduced payment for excess hospital readmissions. Starting in Medicare, with authority for HHS to expand successful strategies through administrative action, thus avoiding stakeholder opposition.²⁵

(6) To allow state innovation (such as single payer approaches)

States may use the new federal subsidies to fund alternatives if they can provide coverage as comprehensive and affordable to as many residents.²⁶

MAJOR IMPROVEMENTS IN HOUSE RECONCILIATION BILL²⁷

- Higher subsidies for low-income groups: share of income on premiums reduced to 2-9.5%; cost sharing reduced for lower-income groups;
- A higher contribution from employers who don't offer coverage: from \$750 in Senate proposal to about \$2000.²⁸
- A reduction in, and postponement of, the Senate excise tax: New threshold: \$10,200 for singles and \$27,500 for families; 2018
- New Medicare taxes for high-income earners (\$200,000 individuals; \$250,000 couples) on payroll (.9% increase) and unearned income: (2.9%)²⁹
- Greater federal Medicaid financing for all states
- Closing the donut hole in the Medicare drug benefit by 2020

SOME IMMEDIATE GAINS (2010-2011)

Seniors: donut hole reduction (after \$2830, until total of \$4550): \$250 rebate in 2010; then 50% reduction in cost of brand-name drugs; no copays for preventive care.

Small business: 35% tax credits for purchase of employee coverage

Children: no pre-existing condition exclusions; dependent coverage until age 26.

The medically uninsured: \$5B for temporary high-risk pool; average premiums.

Insurance coverage reforms: no rescissions, new independent appeals process.

Insurance premium limits: no lifetime limits on coverage, no unreasonable annual limits, new MLR requirements; annual premium increase justification.

IV. WHAT ARE THE REAL GAINS?

- **New coverage for at least 32 million people! 95% will be covered.**³⁰
 16m in Medicaid, 24m in Exchanges
 (5m leave individual market; 4m leave employer coverage)
 Reduction in uninsured to 23 million, vs 56-66m without reform.
- **More comprehensive and affordable coverage**

Cost to Individuals with Average Health Use in the Individual Market vs the New Reform Bill³¹

	Percent FPL	Income	Premium	Plan value ³²	Average Out-of-Pocket Spending	Average total spending	Average % income
Existing Individual Market	133%	\$14,404	\$3712	55%	\$2180	\$5892	\$40.9%
	400%	\$43,320	\$3712	55%	\$2180	\$5892	13.6%
New Reform Bill	133%	\$14,404	\$432	94%	\$301	\$733	5.1%
	400%	\$43,320	\$3436	70%	\$1553	\$4988	11.5%

See the UC Berkeley Labor Center Calculator to estimate costs at other income levels³³

- **Reduction in the federal deficit**³⁴
 By 2019: \$138Billion.
 By 2029: about \$1.2 Trillion
- **Improved Medicare coverage, quality, and fiscal solvency**
Benefits: elimination of donut hole, no copays for preventive services.
 Reduced subsidies of MA enrollees by non MA enrollees
Quality: incentives for better care, better outcomes
Fiscal solvency: extended for 10 years, until 2027³⁵

SPECIFICALLY FOR CALIFORNIANS:³⁶

New coverage for the uninsured, better coverage for the individual market

	<u>For the uninsured (6.4m):</u>	<u>For those in individual market (2m)</u>
Medicaid:	26%:	8%
Subsidies in Exchange:	26%	24%
Employer coverage (ESI)	10%	15%
Income above 400% FPL	13%	47%
Undocumented (1.2m)	20%	

In sum, for 6.4m uninsured in 2007**

- 1.7m gain Medicaid
- 2.2m gain subsidies in Exchange
- 1.9m gain access to Exchange, without subsidies

**The number of uninsured increased to 8.2 million in 2009.³⁷

VIII. WHAT'S NEXT?

An ongoing opposition attack: “repeal and replace”

Republican “Roadmap”³⁸

Privatizing Medicare, reducing Medicare benefits,
deregulating insurance, drastically shifting costs to individuals.

Myriad challenges: State attorneys general, state legislatures, etc.

Opposition rage: racial epithets, knives, threats to legislators.

Countering the attack: Clarify the gains, challenge the misinformation³⁹, e.g.:

- “**Democrats have defied public support**”
→ The public supports reform! increasingly, and especially better informed!!⁴⁰
- “**The bill is a budget buster**”
→ CBO analysis shows the bill will reduce the deficits;
Without reform, Medicare becomes insolvent in 2017.
- “**The bill slashes Medicare and hurts seniors**”
→ Medicare benefits and solvency are strengthened; unfair subsidies are eliminated; cost-effective reforms reduce Medicare spending, federal deficits

And work to restore civility and reason to the discussion.

Preserving the gains!

Continuing the fight for stronger measures: all included in the original House bill

A public option! more cost-effective, generates more price competition⁴¹

A national exchange: greater bargaining power

A real employer mandate: all must pay or play (with small business protections)

Application of all insurance reforms to all employer plans

Inclusion for undocumented immigrants: eligibility for Exchanges

The ERISA waiver: passed by committee, excluded from final House bill.

How can we support the national effort?

- Talk to our political leaders! Thank them for passing historic legislation!
Show them Americans have not rejected comprehensive reform!
Support efforts to defend and strengthen the legislation.
- Support advocacy groups
- Talk to all of our “friends and relations”

Handy contact list:

President Obama: <http://www.whitehouse.gov/contact/> 202-456-1111

House Speaker Nancy Pelosi: <http://www.speaker.gov/> 202-225-4965

Senate Majority Leader Harry Reid: <http://reid.senate.gov/> 202-224-3542

California Senators

Diane Feinstein: <http://feinstein.senate.gov/> 202-224-3841

Barbara Boxer: <http://boxer.senate.gov/> 202-224-3553

Representatives: http://www.house.gov/house/MemberWWW_by_State.shtml

Key advocacy groups:

EQUAL coalition for Equitable Quality Universal Health Care.

<http://www.centerforpolicyanalysis.org>. Join our listserv:

send a blank email to: join-equal@list.equalhealth.info

Health Care for America Now: <http://www.healthcareforAmericanow.org>.

UHCAN: Universal Health Care Action Network. <http://uhcan.org>.

Move-On: <http://www.moveon.org>

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- ¹ I My passion for this effort stems from teaching health policy at San Francisco State University for more than 25 years. I welcome further discussion: please feel free to contact me at dleveen@earthlink.net. I am also happy to send you an electronic copy of this handout if you'd like easier access to the references.
- ² The best examples are the letters circulated in the House and Senate urging Leader Reid to incorporate a public option in a reconciliation bill. At latest count, 120 Representatives had signed the House letter, and 51 senators had either signed or expressed support. See [http:// WhipCongress.com](http://WhipCongress.com).
- ³ The “million calls campaign” orchestrated by major progressive groups on February 24 generated over a million calls in 8 hours. HCAN, MoveOn, DFA, Progressive Congress Action Fund, and Campaign for America’s Future were among the major supporters. <http://pol.moveon.org/virtualmarch10/action.html>
- ⁴ Stolberg et al provide an excellent summary of “the long road back” and the critical role of Obama and Pelosi. The Long Road Back: Tactics, Perseverance and Luck Resurrected a Bill. New York Times 3/21/10
- ⁵ Senator Bernie Sanders, one of the most passionate supporters of single payer legislation, is quoted in today’s New York Times as saying the risk of losing everything if we were to try to incorporate a public option amendment into the reconciliation bill is simply not worth it. David Herszenhorn, A Grand Achievement, Or a Lost Opportunity? New York Times 3/25/10
- ⁶ 80% of the uninsured are in working families, 90% in low-moderate income families. 67% have incomes below 200% FPL; 90% below 300% FPL (FPL: \$22,000 family of 4). Kaiser Family Foundation, The Uninsured and the Difference Health Insurance Makes. Fact Sheet, September 2009. <http://www.kff.org/uninsured/upload/1420-11-2.pdf>
- ⁷ In its analyses of the Democratic bills, CBO projects 54 million uninsured in 2019. The Urban Institute developed three scenarios based on alternative economic assumptions and projected a high of 66 million if unemployment doesn’t improve substantially and health costs continue to rise. See John Holahan et al, Health Reform: The Cost of Failure. Urban Institute and Robert Wood Johnson Foundation. May 21, 2009. p.2. <http://www.rwjf.org/files/research/costoffailurefinal.pdf>
- ⁸ The percent with employer coverage has dropped from 66% in 1999 to 60% in 2009. Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits: 2009 Summary of Findings. <http://ehbs.kff.org/pdf/2009/7937.pdf>
- ⁹ Those with pre-existing conditions face much higher premiums, and often find no insurance available at any price on the individual market. See Doty, Michelle et al. Issue Brief: Failure to Protect. why the Individual Insurance Market is not a Viable Option for Most US Families. Commonwealth Fund, July 2009. http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf
- ¹⁰ The Urban Institute estimated 22,000 deaths due to lack of insurance. Dorn, Stan. Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality. Urban Institute, January 2008. http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf More recently, researchers affiliated with Harvard conducted a different analysis and concluded that lack of insurance caused 45,000 deaths. Wilper, Andrew et al, Health Insurance and Mortality in US Adults. American Journal of Public Health, December 2009, 99 (12) 1-7. <http://www.pnhp.org/excessdeaths/health-insurance-and-mortality-in-US-adults.pdf> (Draft: 2nd Proof)
- ¹¹ Hilzenrath, David. Employers plan to shift more health-care costs to workers, survey reports. Washington Post, March 12, 2010.
- ¹² Kaiser Family Foundation, News Release re: 2009 Employer Benefits Survey, September 15, 2009. <http://www.kff.org/insurance/ehbs091509nr.cfm>
- ¹³ CMS, Estimated Financial Effects of the “Patient Protection and Affordable Care Act of 2009,” as Passed by the Senate on December 24, 2009. January 8, 2010. http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf
- ¹⁴ Budget Director Peter Orszag has repeatedly stated that the federal deficit cannot be reduced unless we can control health care spending. See <http://www.cbo.gov/publications/collections/health.cfm>
- ¹⁵ The best sources of information about the Democratic bills are the following:
For the House bill, all of the major documents, including the section-by-section summaries, are listed at <http://www.speaker.gov/newsroom/legislation?id=0327>.
For the Senate bill, these major documents are listed at http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm
The President’s proposal is at <http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>
The House Reconciliation bill: House Rules Committee, HR 4872, The Health Care & Education

Affordability Reconciliation Act of 2010, Section-by-section analysis. 3/18/10.

http://www.rules.house.gov/111_hr4872_secbysec.html

The Kaiser Family Foundation maintains a continually updated side-by-side comparison at http://www.kff.org/healthreform/upload/housesenatebill_final.pdf, updated 2/22/10.

The many CBO analyses of the bills can be found on the CBO website: <http://www.cbo.gov>

¹⁶ At the signing ceremony for the Senate bill, President Obama described the legislation as enshrining “the core principle that everybody should have some basic security when it comes to their health care.”

Leonhardt, “Health Care Overhaul Becomes the Law of the Land.” New York Times 3/24/10

¹⁷ “Everyone” except undocumented residents: only the House bill allows them to purchase coverage through the new exchanges.

¹⁸ OPM: Office of Personnel Management, which manages the Federal Health Employees Benefit Program.

¹⁹ Health care spending is highly concentrated: 80% goes to the 20% sickest individuals. Thus most individuals never reach the out of pocket limits. Indeed one estimate finds that only 8-12% of individuals and 9-16% of California families eligible for subsidies in the Exchange would reach their out of pocket limits. See Ken Jacobs et al, How Would Health Care Reforms Change the Spending of California Families Without an Employer Plan? UC Berkeley Center for Labor Research and Education. December 2009. p.7 http://laborcenter.berkeley.edu/healthpolicy/affordability_analysis09.pdf

For an analysis of the concentration of health spending, see Zuvekas, Samuel H and Joel W Cohen, Prescription Drugs and the Changing Concentration of Health Care Expenditures. Health Affairs 26(1) January/February 2007, 249-257. See also the Kaiser Family Foundation chart,

<http://www.kff.org/charts/112706.htm>

²⁰ “Affordable” is defined as less than 9.8% of income, and minimum coverage requires an actuarial value of 60%. Actuarial value refers to the share of covered costs covered by the insurance plan, on average across a given population. 60% is lower than most employer plans, lower than the House bill, but higher than plans on the individual market, which are generally around 55%.

²¹ MLRs are Medical Loss Ratios: the percentage of revenues which insurance companies “lose” to pay out claims. The minimum MLR requirements specify the percentage of revenues which insurance companies must pay out on claims: 80% in the individual and small group market and 85% in the large group market.

²² The penalty for noncompliance is \$325 in 2015, \$695 in 2016, or 1% income in 2014, 2% in 2015, and 2.5% in subsequent years. Income below the filing threshold is exempted. HR 4872 Sec 1002.

²³ Paul Van de Water, Health Reform Essential for Reducing Deficit and Slowing Health Care Costs.

Center for Budget and Policy Priorities, February 3, 2010. <http://www.cbpp.org/files/2-3-10health.pdf>

p.5. The Board is also charged to make binding recommendations to reduce overall health spending if it exceeds the growth in Medicare spending. Sec 10320, SBS p.67.

²⁴ Payment and delivery system reforms offer tremendous potential for savings. Two major sources of information about such savings are the Dartmouth Medical Atlas and the Commonwealth Fund. See, for example, Dartmouth Atlas White Paper, An Agenda for Change. December 2008

http://www.dartmouthatlas.org/topics/agenda_for_change.pdf, and Davis, Karen et al, Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate. December 2009, Updated January 7, 2010.

<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Nov/Starting-on-the-Path-to-a-High-Performance-Health-System.aspx>

²⁵ Van de Water, op cit.

²⁶ Senate bill Section 1332.

²⁷ The House bill was much stronger in many ways than the Senate bill. The Reconciliation bill consisted primarily those changes reportedly agreed to by House and Senate leadership on January 15 and those proposed by President Obama on February 22. For a good summary, see

<http://docs.house.gov/energycommerce/KEYIMPROVEMENTS.pdf>

²⁸ Employers are not required to offer coverage; however if any of their employees qualify for subsidies in the new Exchanges, they must pay \$2000 per employee for all of their employees, regardless of whether they qualify for subsidies. The first 30 employees are not counted in this assessment.

²⁹ David Leonhardt points out the redistributive impact of the increased Medicare taxes for higher income people in his article in yesterday’s New York Times: Health Care Overhaul Becomes the Law of the Land; In the Process, Pushing Back at Inequality. 3/24/10. Income growth over the last 30 years has been so highly concentrated at the top income levels—384% for the top .01%; 200% for those in the top 1%--while median income has increased only 12%--that this kind of tax seems eminently fair.

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- ³⁰ CBO letter to Nancy Pelosi, March 18, 2010
- ³¹ Because the President's affordability proposals were incorporated into the House Reconciliation bill, this table, which presents the UCB Labor Center estimates of the impact of the President's proposal, effectively describes the impacts of the final reform. See Jacobs et al, The President's Health Reform Proposal: Impact on Access and Affordability in California. UC Berkeley Labor Center, February 2010. http://laborcenter.berkeley.edu/healthcare/presidents_health_reform10.pdf
In addition, Jacobs et al emphasize that because of the concentration of spending among the sickest, average spending is higher than median spending. See Footnote 19 above.
- ³² "Plan value" refers to Actuarial Value, the average amount of covered medical expenses that are covered by insurance rather than patient out-of-pocket spending. The higher the actuarial value, the lower the copays, deductibles, etc.
- ³³ http://laborcenter.berkeley.edu/healthpolicy/Health_Reform_Calculator_UCB_CLRE_2009.xls
- ³⁴ Speaker Nancy Pelosi, Office, Four Key Points You Need to Know about the New CBO Score. Posted March 20, 2010. <http://www.speaker.gov/blog/?p=2203>
- ³⁵ CMS, op cit.
- ³⁶ Jacobs, Ken et al, Californians' Access to Coverage under the Health Reform Proposals. UC Berkeley, Center for Labor Research and Education, Data Brief. December 2009. http://laborcenter.berkeley.edu/healthpolicy/access_to_coverage09.pdf
- ³⁷ Laverreda, Shana, et al, Number of Uninsured Jumped to More than Eight Million from 2007 to 2009. UCLA Health Policy Research Brief, March 2010. <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=401>
- ³⁸ A Roadmap for America's Future, Version 2.0. January 27 2010. <http://www.roadmap.republicans.budget.house.gov/UploadedFiles/Roadmap2Final2.pdf>
- ³⁹ An excellent source of information for rebutting the myths is by Steven Findlay and Lynn Quincy from the Consumers' Union, posted on the Health Affairs blog, March 16, 2010 <http://healthaffairs.org/blog/2010/03/16/a-consumers-advocacy-group-refutes-the-anti-health-reform-myths/>
- ⁴⁰ See for example the recent analysis by Greenberg et al. Support for Health Care Reform on the Rise after Massachusetts. March 9, 2010. It shows both responses to the general question of support vs opposition (46% to 47%) and the much greater support for specific elements of the proposed legislation. http://www.democracycorps.com/wpcontent/files/HCR03092010.FINAL_.pdf. And a new USA TODAY/Gallup poll finds 49% say passage of the bill was a good thing. See Page, Poll: Health Care Plan gains favor. USA Today 3/23/10. http://www.usatoday.com/news/washington/2010-03-23-health-poll-favorable_N.htm
The Kaiser Family Foundation monthly Tracking Surveys show that the more individuals understand about the legislation, the more they support it. The February survey is at <http://www.kff.org/kaiserpolls/upload/8051-F.pdf>
Finally, a Bloomberg poll (March 19-22) cited in the San Francisco Chronicle (3/24/10) shows incredible contradictions in the public's attitudes: 50% oppose the overhaul, 53% think the bill is a government takeover, 60% think health care is a private matter, and **64%** think "health care is like policy and fire protection and the government has a role in making sure everyone has access to care they can afford."
The need for and potential value of public education is enormous!!
- ⁴¹ The best analyses of the potential effectiveness of a truly robust public option (i.e. using Medicare rates as the basis for reimbursement) come from Jacob Hacker and the Commonwealth Fund. Hacker's original proposal: Health Care for America: A Proposal for Guaranteed, Affordable Health Care for all Americans Building on Medicare and Employment-based Insurance. EPI Briefing paper #180, January 11, 2007. And the Lewin Group analysis of his proposal: Cost impact analysis for the "Health Care for America" Proposal. February 15, 2008. <http://www.sharedprosperity.org/hcfa/lewin.pdf>
The Commonwealth Fund has myriad analyses of reform proposals which include a public option as well as extensive payment and delivery system reforms. See their website: <http://www.commonwealthfund.org/>, either on the home page or in publications on "health system performance." They have also employed the Lewin Group to analyze the cost-savings which, when combined with effective payment and system delivery reforms, could be dramatic.