HEALTH IN REFORM 2010

Understanding The Patient Protection and Affordability Act and Its Impact On You

An Independent Analysis of Health Care in the United States

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Overview & Summary

Introduction: Understanding the Patient Protection and Affordability Act and its Impact on You

On March 22, President Barack Obama signed The Patient Protection and Affordability Act into law, making historic changes to our nation's health care system. This report takes a look at how that change will affect you – the American consumer. Before looking at the impact of the law, this report begins with a summary of the law and its many parts, particularly those that apply to consumers. It then discusses the complex timeline for implementation – not all changes to the law take effect at the same time. Next, it contains a brief discussion of how all these changes will be paid. It ends with a set of scenarios that will help people understand how the new law affects consumers from all walks of life.

Summary: The Patient Protection and Affordability Act

The new law requires most Americans (U.S. citizens and legal residents) to have health insurance. There are a handful of exceptions. The law requires large companies either to offer their employees health insurance, or pay fees. The law also creates "health insurance exchanges" – basically a marketplace where individuals and small businesses can shop for insurance.

Coverage under health reform can be categorized into three major groups: 1. Individuals and Families, 2. Small Employers, and 3. Large & Mid-size Employers (see Figure 1). Individuals and families have the option of shopping on the health insurance exchange - as do small employers. Government subsidies will be offered to individuals, families, and small employers on a sliding scale that uses the Federal Poverty Level (FPL) as a baseline. Large businesses with more than 100 employees will not receive subsidies.

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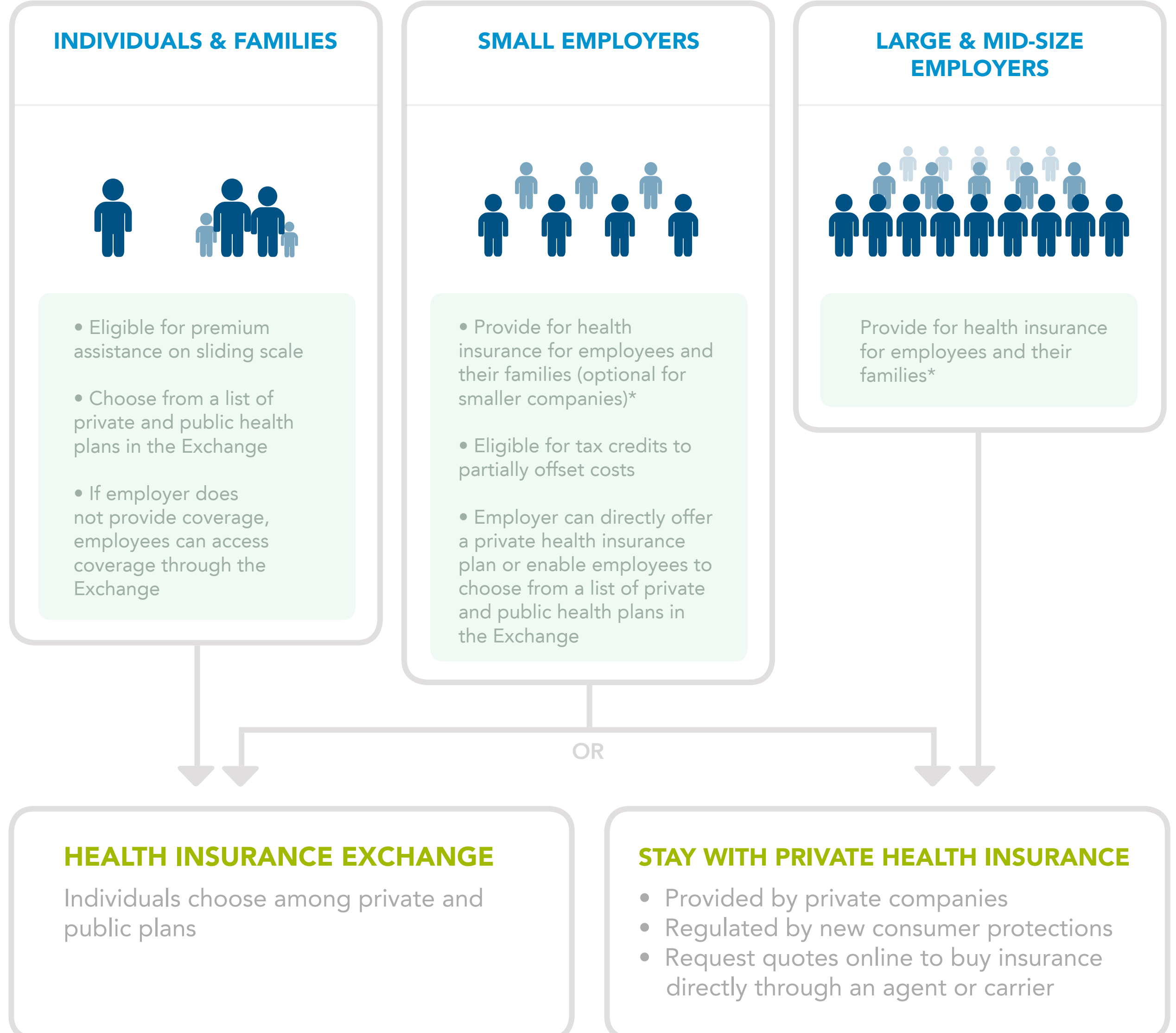

Figure 1

Source: Health Care for America Now

- Reforms To Prevent Insurers From Denying Or Dropping Coverage
- Comprehensive Benefits
- Assistance For Low and Moderate Income Families

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Requirements of Health Reform

Requirements for Individuals

U.S. citizens and legal residents are mandated, under the new law, to purchase health insurance. People who don't have insurance will either pay 2.5 percent of their household income, or a penalty of $695 per person ($2,085 per family) – whichever amount is greater. Fines will be phased in over time, beginning in 2014. There will be some exceptions for people who have financial hardships or religious objections. Native Americans, people with insurance for less than three months, undocumented immigrants, prisoners and very low income individuals will be exempt as well.

Requirements for Small Businesses

Small businesses – those with up to 100 employees – will be able to buy their employees insurance through the small business exchange. Small businesses with 25 employees or less, whose employees earn an average of $50,000 a year or less will get a tax credit for buying their employees insurance. There will also be tax credits for employers who share the cost of buying their employees insurance through the new exchange. The credit phases out as firm size and average employee wage increases, so that companies with more employees earning higher wages get a smaller tax credit.

Requirements for Large Businesses

Large employers (those with more than 200 employees), who offer their employees insurance, will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or opt out of coverage. Those who opt out may choose to purchase insurance through the exchange.

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Businesses with more than 50 employees that do not offer health insurance (and have at least one full time employee) will likely pay fees. If any of their employees buys insurance through the exchange, and is eligible for a premium credit (here we mean employees earning less than 400 percent of federal poverty level or about $41,500 annually), the business will pay a fee of $2,000 per employee (this fee does not apply to the first 30 employees).

Businesses that offer insurance that is "expensive" [1] may see these employees go to the exchange as well. If an employee buys insurance through the exchange, the business will pay a fee – the lesser of $3,000 for each employee who receives a premium credit in the exchange or $2,000 for each full-time employee.
Finally, in some cases, businesses would have to pay for vouchers. Individuals earning in the $41,500 range who would have to pay 8 to 9.5 percent of their household income on premiums for their employer's health insurance may be eligible for a voucher from their employer. The voucher is equal to the amount the employer would have spent on their health insurance under the employer's insurance plan.

Employees can use these vouchers towards the purchase of an individual health insurance plan from the state-run exchanges.*

Preexisting Conditions

One of the most significant changes the law makes is that – starting in 2014 – individuals can buy insurance even if they have a preexisting medical condition. The law also gives subsidies to people in order to help make insurance more affordable – lower income Americans will receive a larger subsidy. The new law expands Medicaid – the states' public insurance program for the lowest income individuals. Finally, it makes some changes to Medicare. Each of these changes will be discussed in detail within this report. First, let's look at why health reform was originally enacted.

* See Page 7 for full details on how the exchanges operate.
1. defined as the employee pays more than 9.5 percent of his of her income on premiums, or that plan doesn't cover more than 60 percent of the cost of benefits

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The health care system in the U.S. - for years - has been subject to rapidly rising costs, particularly for some of the most common preexisting conditions among Americans. Insurance companies have responded to these rapidly rising costs, in part by raising premiums, but also cutting benefits. The most effective means used to cut benefits is to exclude coverage for the most expensive preexisting conditions. In fact, 9 of the 10 most costly medical conditions could be considered "preexisting" - only one (trauma), would not fall under this category (see Figure 1.1).

Health Reform was meant to end the insurance company practice of denying coverage based on these conditions, because the majority of the public (80%) favors a requirement for insurance companies to cover people - regardless of their preexisting condition.[1] In response, the 2010 Health Reform law required insurers to cover people with preexisting conditions.

10 Most Costly Medical Conditions

Changes In Nominal Healthcare Spending From 1987-2000

Medical Condition	Total Change in Spending (millions of dollars)	PERCENT CHANGE IN SPENDING ATTRIBUTABLE TO		
		Increased Cost per Treated Case	Rise in Treated Prevalence	Increased Population
Heart Disease	26,228.5	68.6	1.1	30.3
Pulmonary Conditions	24,792.0	37.5	41.9	20.6
Mental Disorders	24,503.3	21.1	59.2	19.7
Cancer	17,734.3	41.9	27.4	30.7
Hypertension	15,385.8	59.8	18.9	21.3
Trauma	14,596.6	169.1	-108.5	39.5
Cerebrovascular Disease	11,078.9	208	60.3	18.9
Arthritis	10.282.8	44.3	31.6	24.1
Diabetes	9,626.8	23.6	49.8	26.6
Back Problems	9,486.4	21.7	52.6	25.8

Figure 1.1 Source: 1987 National Medical Expenditure Survey (NMES) and 2000 Medical Expenditure Panel Survey, Household Component (MEPS-HC)

Note

All changes were significant at the .O5 level, except for change in spending, kidney disease (at the .10 level); rise in treated prevalence, heart disease (not significant); and increased cost per treated case, endocrine and kidney disease (not significant). Medical conditions ranked by change in spending between 1987 and 2000.

1. According to "TIME magazine/Abt SRBI — July 27–28, 2009 survey" New York: Abt SRBI. http://www.srbi.com/TimePoll4794_Final_%20Report.pdf. Retrieved May 05, 2010.

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Getting Health Coverage Under the New System

Under the new law, Americans will be able to get insurance in one of five ways: (1) Through their employer, (2) buying insurance direct through an agent, online, or through a carrier, (3) through the exchanges, (4) from the government (for example, if they are very low income and qualify for Medicaid, are seniors on Medicare, are members of the military on Veteran's benefits, etc) or (5) through their parents, starting this year (young adults up to age 26 will be able to stay on their parents' insurance).

For individuals that get their insurance through their employer, not much will change. Employer-offered insurance will need to meet some requirements to be considered valid. Employers with more than 200 employees must automatically enroll their employees into their health insurance plan if they offer one, though people can then opt out. Those who do opt out can buy insurance on their own in the exchange.

The New Health Insurance Exchanges

Starting in 2014, for individuals buying insurance on their own, the new exchange will provide marketplaces where individuals (and families) will be able to shop for insurance. Small businesses will have an exchange as well. Unlike the current "insurance market," people who use the exchanges will be able to buy insurance, regardless of whether they have a preexisting medical condition. Premiums will not vary depending on an individual's health status or gender (as is the case today). There will be no limits on maximum lifetime coverage.

To make shopping in exchanges easier, a new system will be created where people will be able to buy insurance that falls into categories. This will make it easier to

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shop "apples to apples." For example, if you are looking at a "gold level" Blue Cross plan you can compare its cost to the "gold level" Aetna plan, where the benefits and coverage will be very similar (see Figure 1.2).

Health insurance exchanges are not new. The 2010 health reform law modeled its idea of an exchange from existing exchanges that have succeeded on a smaller scale. Massachusetts was the first state to require coverage when, in 2006, it set up the Commonwealth Health Insurance Connector Authority. Much like the exchanges described in the 2010 federal bill, the Massachusetts exchange is essentially a one-stop shop, managed by the state government, which allows you to compare plans using three levels of basic coverage (see Figure 1.2).

What The New Exchange Could Look Like

Health Insurance Companies	Bronze • Lower monthly cost • Higher costs when you receive medical services	Silver • Monthly costs can run higher than Bronze • Lower medical costs	Gold • Highest monthly cost • Lower costs when you receive medical services
CELTICARE Health Plan of Massachusetts	3 plans from **$262.15** Total Monthly Cost	3 plans from **$375.10** Total Monthly Cost	3 plans from **$455.07** Total Monthly Cost
Neighborhood Health Plan	3 plans from **$265.81** Total Monthly Cost	3 plans from **$371.26** Total Monthly Cost	3 plans from **$454.05** Total Monthly Cost
TUFTS Health Plan	3 plans from **$279.73** Total Monthly Cost	3 plans from **$337.98** Total Monthly Cost	3 plans from **$483.14** Total Monthly Cost
Harvard Pilgrim HealthCare	3 plans from **$336.22** Total Monthly Cost	3 plans from **$485.00** Total Monthly Cost	3 plans from **$638.61** Total Monthly Cost
fallon community	3 plans from **$354.00** Total Monthly Cost	3 plans from **$478.00** Total Monthly Cost	3 plans from **$630.00** Total Monthly Cost

Figure 1.2 Source: Massachusetts Health Connector, Business Express Exchange. https://businessexpress.pivot.com

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Government Subsidies for Low-Income Americans

Within the exchange, many individuals will also be eligible for government subsidies to make health insurance more affordable. Starting in 2014, individuals who reach certain income requirements will get "premium credits" to help them afford insurance. The credit will ensure they spend no more than a certain percent of their income on health insurance premiums.

Premium credits will be provided by the government to qualified individuals who fall within certain income requirements (ranging from 133% to 400% of the Federal Poverty Level). Currently, the Federal Poverty Level is around $10,830 for a single individual and $22,050 for a family of four. Individuals and families can purchase coverage on a health insurance exchange using the government-provided premium credit. The government credit ensures that families within certain income thresholds will not spend more than a certain amount of their income on health insurance coverage (see Figure 1.3).

Income Earned Each Year*	Percent of Income Spent on Health Coverage
≤ 133% of federal poverty**	≤ 2%
133-150% ($14,000 to $15,500)	Between 3% to 4%
150-200% ($15,500 to $21,600)	Between 4% to 6.3%
200-250% ($21,600 to $27,000)	Between 6.3% to 8.05%
250-300% ($27,000 to $32,500)	Between 8.05% to 9.5%
300-400 of ($32, 500 to $41,500)	No more than 9.5%

Figure 1.3 Source: From the Kaiser Family Foundation, Summary of Final Health Reform Law

* Represented by a percentage of the Federal Poverty Level (As of 2010, it is $10,830 for an individual and $22,050 for a family of four).
** About $14,000 for an individual

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Options for Individuals with Preexisting Conditions

Until the exchange is up and running in 2014, the law establishes a temporary national high-risk pool to provide health coverage to individuals with preexisting medical conditions. U.S. citizens and legal immigrants who have a preexisting medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums.

Options for Low-Income Americans

Low-income Americans may be able to get their insurance through a public program – Medicaid. Those who have incomes up to about $29,300 for a family of four will be eligible for Medicaid, starting in 2014. The law also specifies that states must maintain current eligibility rules for their State Children's Health Insurance Programs.

Provisions of Health Reform for Young Adults

The health reform law expands coverage for young adults. This is especially helpful to young adults who rely on their parents' coverage to cover the costs of health care. Young adults who aren't enrolled in an institution of higher education often find themselves denied coverage on their parents' plans as soon as they reach the age of 18 (many plans require that children on a parent's plan are full-time students). A study by the Commonwealth Fund found that two-thirds of uninsured young adults either skipped care or did not fill a prescription because of cost concerns. Only one-third of young adults who had coverage did the same (see Figure 1.4). The health reform law now requires insurers to cover children under their parents' plan until the age of 26 - whether or not they are attending school. This requirement goes into effect in 2010.

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Two-Thirds of Uninsured Young Adults Had Cost-Related Access Problems in the Past Year, Compared with One-Third of Those Who Were Insured All Year

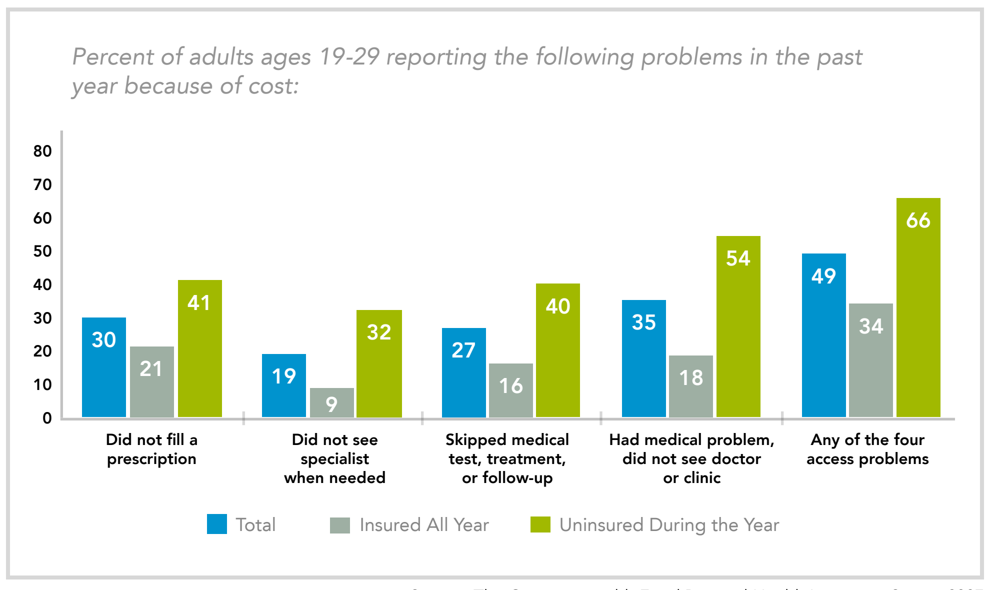

Figure 1.4 Source: The Commonwealth Fund Biennial Health Insurance Survey 2007

Insurance Options for Seniors

Most Americans over 65 will continue to be eligible for Medicare. The law makes numerous changes to the Medicare program to improve its performance and reduce the cost of the program, as well as the costs to some individuals. Higher income individuals and families will no longer receive subsidies. However, starting in 2020 prescription drugs will become more affordable to seniors by closing the existing "donut hole" in the program (see Figure 1.5). (The gap commonly known as "the donut hole" refers to the amount seniors pay between their initial drug coverage limit and the point at which catastrophic coverage kicks in. For seniors who spend approximately $3,000 to $6,000 on drugs each year, they find they must pay out-of-pocket.) The law begins closing the gap by providing a $250 rebate to seniors in the gap, which starts this year once they have spent $2,830. The amount increases, and the "donut hole" would be fully closed by 2020.

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The Donut Hole Coverage Gap Will Be Eliminated By 2020

Standard Medicare Prescription Drug Benefit, 2009

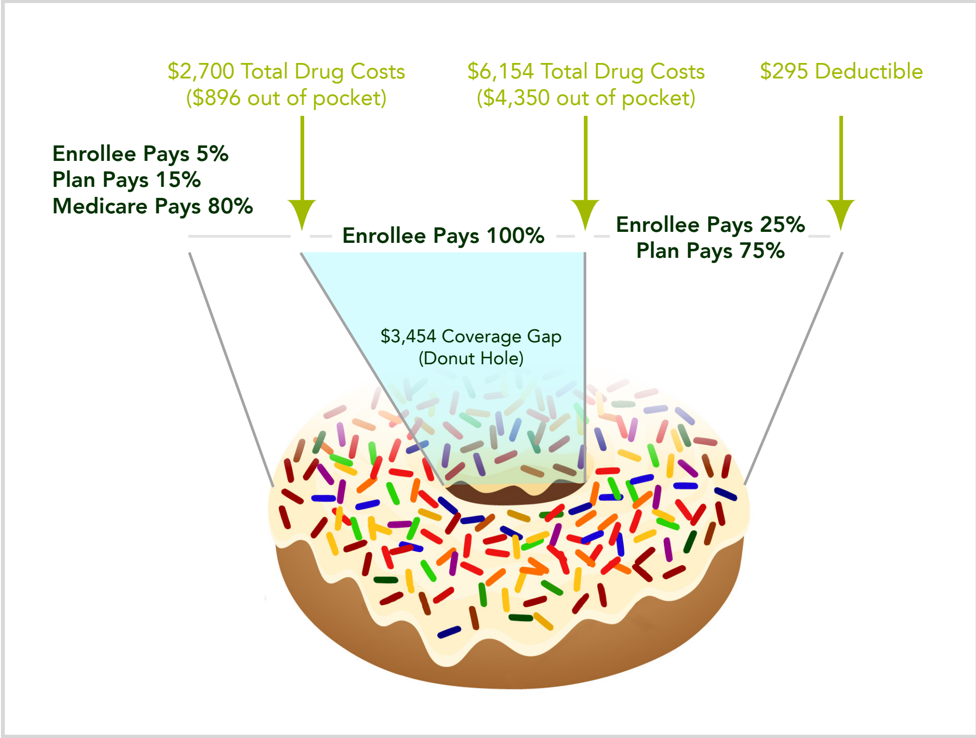

Figure 1.5 Source: "The Gavel" U.S. Speaker of the House of Representatives. http://www.speaker.gov/blog/?p=2054

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A Health Reform Chronology

- High-risk health insurance pool begins providing coverage to uninsurable people
- Children can stay on their parents' coverage until the age of 26, and preexisting condition exclusions for children become prohibited
- Tax credits will help small businesses with 25 employees or fewer get coverage for employees

- Medicare recipients who fall in the coverage gap are given a 50% discount on brand name drugs
- Payments to private Medicare Advantage plans will be frozen and gradually reduced over 3 to 7 years
- Employers will be required to report the value of health care benefits on employees' W-2 tax statements

- Sets up program to create nonprofit insurance co-ops that would compete with commercial insurers
- Penalizes hospitals with high rates of preventable re-admissions by reducing Medicare payments

- Tax-exempt flexible spending accounts (FSAs) will be limited to $2,500 a year for medical expenses. Threshold for claiming the FSA tax deduction is raised to 10% of income for most people other than seniors
- New taxes enacted for people who earn more than $200,000 ($250,000 for couple). Medicare taxes for these groups would go up 2.35%, and investment taxes would be raised by 3.8%. New 2.3% sales tax for medical devices (certain items, such as eyeglasses, contact lenses, and hearing aids will be exempt)

- Prohibits insurers from denying coverage to people with preexisting conditions
- Affordable coverage will be available through online health insurance exchanges. Consumers are provided with income-based vouchers to use in the exchanges, substantially reducing costs
- Consumers can still purchase health insurance directly through agents and carriers, or by requesting a quote online
- Requires citizens and legal residents to have health insurance, except in cases of financial hardship, or pay a fine to the IRS. Penalty starts at $95 per person in 2014, rising to $695 in 2016. Family penalty capped at $2,250. Penalties indexed for inflation after 2016

- Taxes enacted for employer-sponsored "Cadillac Health Insurance" (plans with premiums that are higher than $10,200 for individual coverage and $27,500 for a family plan)

Source: Health Overhaul: Immediate Change, Long Term Steps

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How the New Law is Funded

The law will be funded using a variety of new fees, taxes and cuts in government health spending (see Figure 1.6).

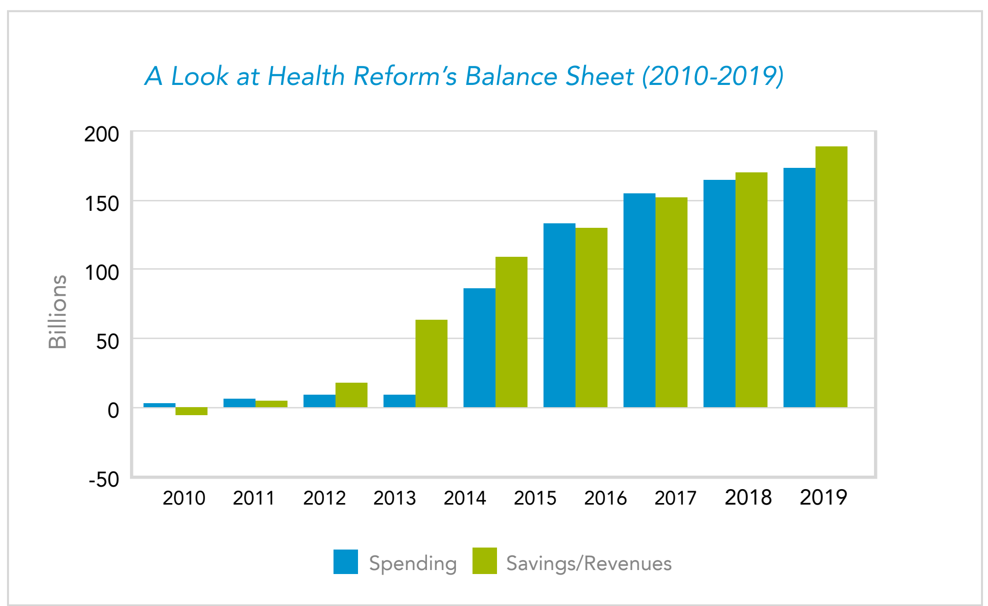

Figure 1.6 Source: The Commonwealth Fund Biennial Health Insurance Survey 2007

Fees

- Pharmaceutical companies will pay fees up to $4 billion per year, while health insurance companies will start by paying $8 billion a year, with that amount increasing over time.

Taxes

- Insurance companies will have new limits on how they can deduct employee compensation from their taxes.
- Consumers will pay a new excise tax of 2.3 percent on medical devices; however, frequently purchased devices (such as eyeglasses and hearing aids) will be exempt.
- There will be a new 10 percent tax on indoor tanning services.
- The Medicare payroll tax will increase for couples making more than $250,000 and individuals making more than $200,000. The tax rate on wages above those

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thresholds would rise to 2.35 percent from the current 1.45 percent. It also adds a new tax of 3.8 percent on income from investments.

- The law imposes a tax on employer-sponsored health insurance worth more than $10,200 for individual coverage, $27,500 for a family plan. The tax is 40 percent of the value of the plan above the thresholds, indexed for inflation.

Payment Cuts

The law freezes payments to Medicare Advantage plans, which is the first step in reducing payments to the private insurers who serve about one-fourth of seniors (see Figure 1.7). The reductions would be phased in over three to seven years.

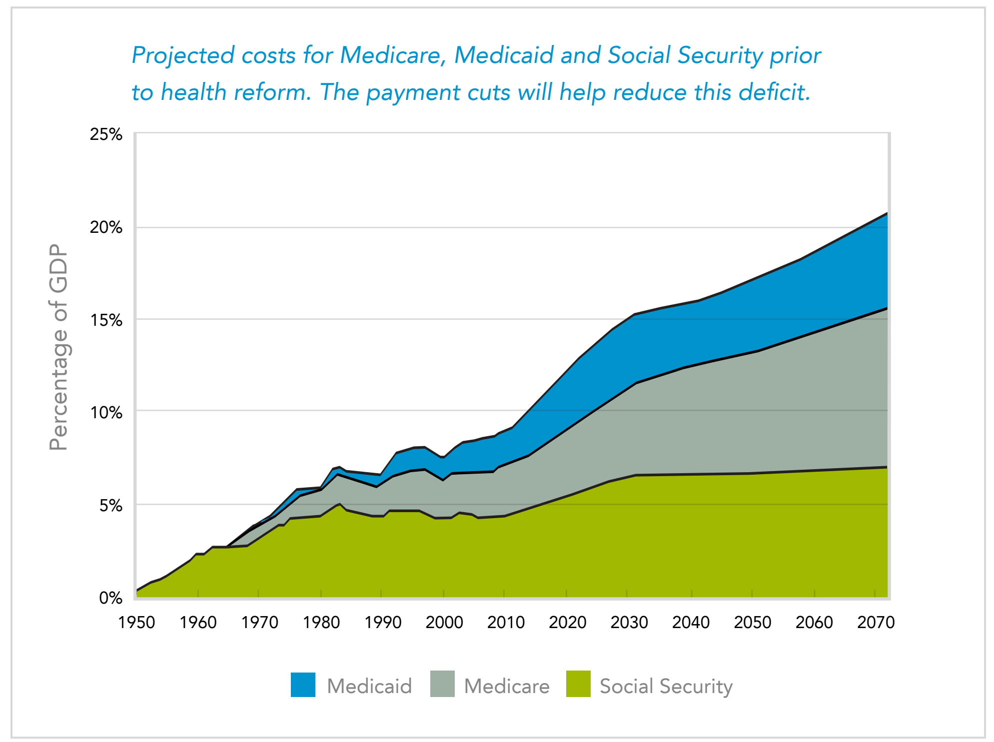

Figure 1.7 Source: Steuerle, C. Eugene "The Incredible Shrinking Budget of Working Families." The Urban Institute.

The law also reduces projected Medicare payments to hospitals, home health agencies, nursing homes, hospices and other providers. For example, hospitals that have high preventable re-admission rates will see their Medicare payments cut.

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How the Law Affects Consumers

Consumer	Effect of the Law
Middle Income Has insurance from employer (earns $50,000 a year)	This consumer will likely experience no change. If they have kids, their children can now stay on a parent's insurance until age 26. Middle income individuals may still be able to save on coverage by requesting a quote online to compare rates.
Lower Income May or may not have insurance (earns about $2,000 a year)	Starting in 2014, everyone is required to have insurance. This person could purchase insurance through the new exchange and get a premium credit, so he or she would spend no more than about $1,000 annually on insurance, or he might be offered insurance from his employer.
Small Business Owner	From 2010 to 2013, the owner can get a tax credit to provide insurance to her employees. After 2014, she can buy insurance for herself and her employees through the small business exchange. If she hires more workers at higher salaries eventually, then she may not be eligible for the credit.
Senior	In 2010, the senior would get a $250 rebate for prescription drugs. Depending how much they spend on prescription drugs each year, over time they may see that amount reduced with additional discounts. More preventive services will be available for free.
Self Employed Earning $30,000 a year	Starting in 2014, he will have to have insurance and can buy insurance through the exchange with a premium credit. His insurance rates won't depend on his health status.
Uninsured Low income family of four, earning $40,000 a year	Starting in 2014, the family will have to have insurance and can receive a credit to help buy coverage from the exchange. If they cannot afford to buy insurance, then they can apply for a hardship waiver. If they can afford coverage and choose not to buy it, they will be fined. Uninsured individuals can also request a quote online to find insurance direct through an agent or carrier. Depending on the number of children they have and other factors, the children may be covered by their state's Children's Health Insurance Program.

Figure 1.8 Source: From the Kaiser Family Foundation, Summary of Final Health Reform Law

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Help for Consumers Trying to Make Sense of it All

To help consumers make sense of it all, the Department of Health and Human Services will create a new website to help Americans identify health coverage options and develop a standard format for presenting information on insurance options. The Department will also implement standards for insurers to use in providing information on benefits and coverage, essentially creating something like a "nutrition label" for insurance plans to help consumers make choices and compare products.

Several other sources, including foundations and nonprofits, have already created resources to help consumers, and more will surely come. http://www.washingtonpost.com/healthcaretool helps people determine how the law will affect them. The Kaiser Family Foundation has several good resources as well MedHealthInsurance.com can help consumers find quality, affordable health insurance plans.

Conclusion

The next several years will be a time of historic change. Many parts of the legislation must still be ironed out through legal interpretations and government regulations.

Fortunately, since not all parts of the bill take effect this year, there is time for Americans to learn more about this complex legislation and how it will affect them. In the decade ahead, the Congressional Budget Office analysis predicts the Patient Affordability and Protection Act will bring health coverage to 32 million Americans – an enormous benefit to these Americans and our country as a whole.

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