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A Glimpse of Health Reform: Coverage, Prevention, and Cost

Health Reform (the Patient Protection and Affordable Care Act) aims to expand public and private insurance coverage, improve the health care delivery system, and increase access to preventive services in the United States.

Changes to Public Coverage

Public coverage currently includes Medicaid, Medicare, Children's Health Insurance Program, and Indian Health Services. The goal of the law is to address certain aspects of each program, including improving access, simplifying enrollment, integrating benefits, expanding prescription drug coverage, improving the quality and efficiency of services offered, providing new options for long-term care resources and supports, and reallocating funding to hospitals caring for a disproportionate share of the uninsured.

Changes to Private Coverage

In the private health insurance market, health insurance companies will be able to contract with a government agency or non-profit organization to participate in a health insurance exchange. The exchange will allow businesses and individuals to select from a range of insurance plans. All plans must offer coverage for essential benefits, as identified in the law.

Other changes will include new rules in the insurance market to increase participation in health plans by removing barriers, expanding eligibility, offering protections against loss of eligibility, improving the quality of services, and expanding choices for insurance coverage. By 2014, all individuals must obtain health insurance or pay a penalty, although some exceptions will apply. Tax credits will be given to allow individuals to purchase insurance in the private market. The expansion of both sectors, public and private, is expected to insure approximately 32 million more Americans.*

Improving Health Care Quality

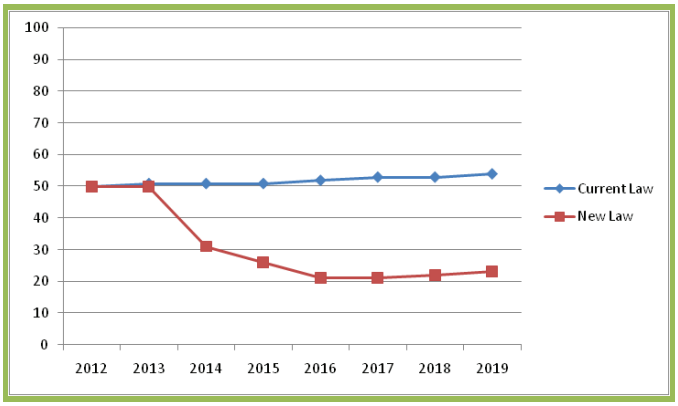
There are provisions intended to streamline and improve the delivery of health care across many areas of the U.S. health care system. The integration of health systems to gain efficiencies, improve quality of care, and reduce spending will be supported. One example is the implementation of accountable care organizations (ACOs), which will encourage physician groups to join together. Health information technology (HIT) will be expanded to adopt uniform data collection, utilize standardized websites, and more. A series of quality-driven incentives and penalties for providers who take Medicare will be incorporated, as well as funding to study and implement evidence-based practices related to the financing and delivery of Medicare and other forms of health care finance.

Improving Health

A major effort to improve health and well-being will be initiated through prevention. Funding will become available and "pilot projects" will be encouraged in the areas of physical activity, nutrition, emotional wellness and smoking cessation. One funding opportunity will be to demonstrate the ability to support the establishment and operation of school-based health centers to serve a large population of Medicaid-eligible children and provide comprehensive primary care services. Research and data collection will also be encouraged in an effort to advance public health innovation.

**Estimated by the Congressional Budget Office, March 20, 2010*

The Trend of the Uninsured in the United States:
*Current Law Compared to Patient Protection and Affordable Care Act***



***Based on estimates by the Congressional Budget Office. Data was adapted after the reconciliation and shows the non-elderly uninsured including unauthorized immigrants.*

Note: Information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Many details will be solidified and may change.

2010: Immediate Actions

A temporary, national high-risk pool will be created for those previously unable to obtain insurance due to poor health.

Lifetime coverage limits will be banned, meaning that there is no limit on what an insurer will pay for the life of the insurance policy. Coverage cannot be cancelled except in cases of fraud, and children cannot be excluded due to pre-existing conditions.

Through a temporary re-insurance program established by the U.S. Department of Health and Human Services, employers providing health insurance coverage to retirees, ages 55-64, may receive financial assistance to offset early retiree claims between $15,000 and $90,000.

Unmarried children up to age 26, regardless of full-time student status, will be allowed to stay on a parent's plan unless offered a choice of plans by their own employer.

Tax credits will be provided to small businesses. This will apply to employers of 25 employees or less with average wages of less than $50,000 who offer coverage that meets minimum requirements.

A rebate of $250 will be provided for those who reach the Medicare Part D "donut hole" in 2010.

2011-2013: Building Infrastructure

Requirements for insurance companies will be tightened. Insurers will now be required to spend 85% of premium revenue on medical claims.

Health Information Technology must adhere to operating rules for electronic funds transfer and health care payments.

Provider payment rules will be developed.

A national, voluntary long-term care insurance program will be created. Premiums will be deducted from every worker's paycheck unless they choose to opt out.

Various committees will be assembled to guide the implementation of programs and regulations.

A national quality improvement strategy will be established to improve the health care delivery system, patient health outcomes, and the overall health of the population.

Regulations will be issued to create health care choice compacts which will allow two or more states to sell insurance products across state lines. Selling across state lines will not be allowed until 2016.

Focusing on Prevention

Medicaid will cover tobacco cessation for pregnant women.

Only proven prevention programs will be covered by Medicare.

Grants up to five years will be provided to small employers to establish wellness programs.

Nutritional content must be displayed in vending machines and chain restaurants with 20 or more locations. Menus must also mention the suggested daily caloric intake.

2014: Expanding Coverage

All individuals must obtain health insurance or pay a penalty. The penalty, in the form of a tax, will first be assessed as 1% of household income, moving to 2.5% in 2016 and beyond. There will be upper income limits and those who can show financial hardship or have religious reasons may be exempt.

States are required to create health insurance exchanges. There will be two types of exchanges, individual and Small Business Health Options Program (SHOP), although states may combine exchanges or propose a state-specific alternative. The individual exchange will be open to individuals who do not have qualifying coverage through an employer or a public program. SHOP will be open to individuals and employers with less than 100 employees.

Coverage cannot be denied for adults with pre-existing conditions.

Essential health benefits packages must include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care).

Tax credits on a sliding scale become available for families below 400% of the federal poverty level (FPL) to purchase insurance in the exchanges. This credit would apply to a family of four earning up to $88,000/year***.

Individuals under the age of 65 who are at or below 133% FPL are eligible for Medicaid. This would apply to a family of four earning up to $29,327/year***.

****2010 dollars*

Cost

Now that we have taken a glimpse of the major areas of health reform involving coverage and preventive measures, what is it going to cost? The total federal cost of expansion is expected to be offset by generated revenue (taxes, penalty payments, employer payments, etc.) and savings from efficiencies in the system. Combined, it is expected to reduce the federal deficit by $124 billion over the next 10 years+.

Approximate Total Federal Cost of Coverage Expansion and Improvement		$940 Billion
Approximate Total Federal Savings & New Revenue++	—	$1,064 Billion
Estimated Reduction to the Federal Deficit by 2019		-$124 Billion

+As estimated by the Congressional Budget Office, March 20, 2010.

++ This total is approximately 50% savings and 50% revenue.

Source: The Congressional Budget Office, March 20, 2010.