What Will Happen Under Health Reform—and What's Next?

THE COMMONWEALTH FUND

A Resource for Journalists from The Commonwealth Fund

Contents

Newly enacted national health reform will begin,

almost immediately, to transform the U.S. health care system in ways large and small. The changes will increase the number of people with health insurance, and affect how many of us obtain coverage, how care is paid for and delivered, and how it is regulated. The Patient Protection and Affordable Care Act of 2010 preserves the current private–public system of employer-based coverage, Medicare, and Medicaid and creates income-based subsidies to make coverage affordable to low- and middle-income families without employer coverage. Many major features of reform begin to take effect in 2010:

- **New insurance rules:** Insurance companies will be banned from rescinding people's coverage when they get sick, and from imposing yearly and lifetime caps on coverage.
- **High-risk pool:** People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool. Premiums will be based on the average health status of a standard population. Annual out-of-pocket costs will be capped at $5,950 for individuals and $11,900 for families.
- **Protection for children:** Insurers can no longer deny health coverage to children with preexisting conditions or exclude their conditions from coverage.
- **Coverage for young adults:** Parents will be able to keep their children on their health policies until they turn 26.
- **Small-business tax credits:** Small businesses (fewer than 25 employees and average wages under $50,000) that offer health care benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.
- **Preventive care:** All new group and individual health plans will be required to provide free preventive care for proven preventive services. In 2011, Medicare also will provide free preventive care.
- **Early retirees:** A temporary reinsurance program will help offset the costs of expensive premiums for employers providing retiree health benefits.
- **"Doughnut hole" rebates:** Medicare will provide $250 rebates to beneficiaries who hit the Part D prescription drug coverage gap known as the "doughnut hole."
- **Annual review of premium increases:** Health insurers will be required to submit justification for premium increases to the federal and relevant state governments before they take effect, and to report the share of premiums spent on non-medical costs.
- **Access to care:** Funding will be increased by $11 billion over five years for community health centers and the National Health Services Corps to serve more low-income and uninsured people.

Timeline for Reform

Reform will unfold incrementally. Although some major elements of reform begin in 2010, others will be implemented over the course of several years. In 2014, the most substantial changes—including shared responsibility for coverage, expansion of Medicaid, insurance exchanges, and creation of an essential benefits package—will take effect.

Premium share spending: Health plans in the large-group market that spend less than 85 percent of their premiums on medical care, and plans in the small-group and individual markets that spend less than 80 percent on medical care, will be required to offer rebates to enrollees.

"Doughnut hole" discounts: Medicare beneficiaries in the Part D prescription drug coverage "doughnut hole" will receive 50 percent discounts on all brand-name drugs. By 2020, the "doughnut hole" coverage gap will be closed.

Medicare value-based purchasing: Medicare will reward hospitals that provide higher quality or better patient outcomes.

2011 → **2012**

Benefit disclosure: Employers will be required to disclose the value of benefits provided for each employee's health insurance coverage on the employee's W-2 forms.

New payment and delivery approaches: A new Center for Medicare and Medicaid Innovation will test reforms that reward providers for quality of care rather than volume of services. Medicare will increase payment for primary care physicians by 10 percent for primary care services.

Physician quality reporting: Medicare will launch a Physician Compare Web site where beneficiaries can compare measures of physician quality and patient experience.

Pharmaceutical manufacturer fee: An annual, nondeductible fee will be imposed on pharmaceuticals and importers' branded drugs, based on market share.

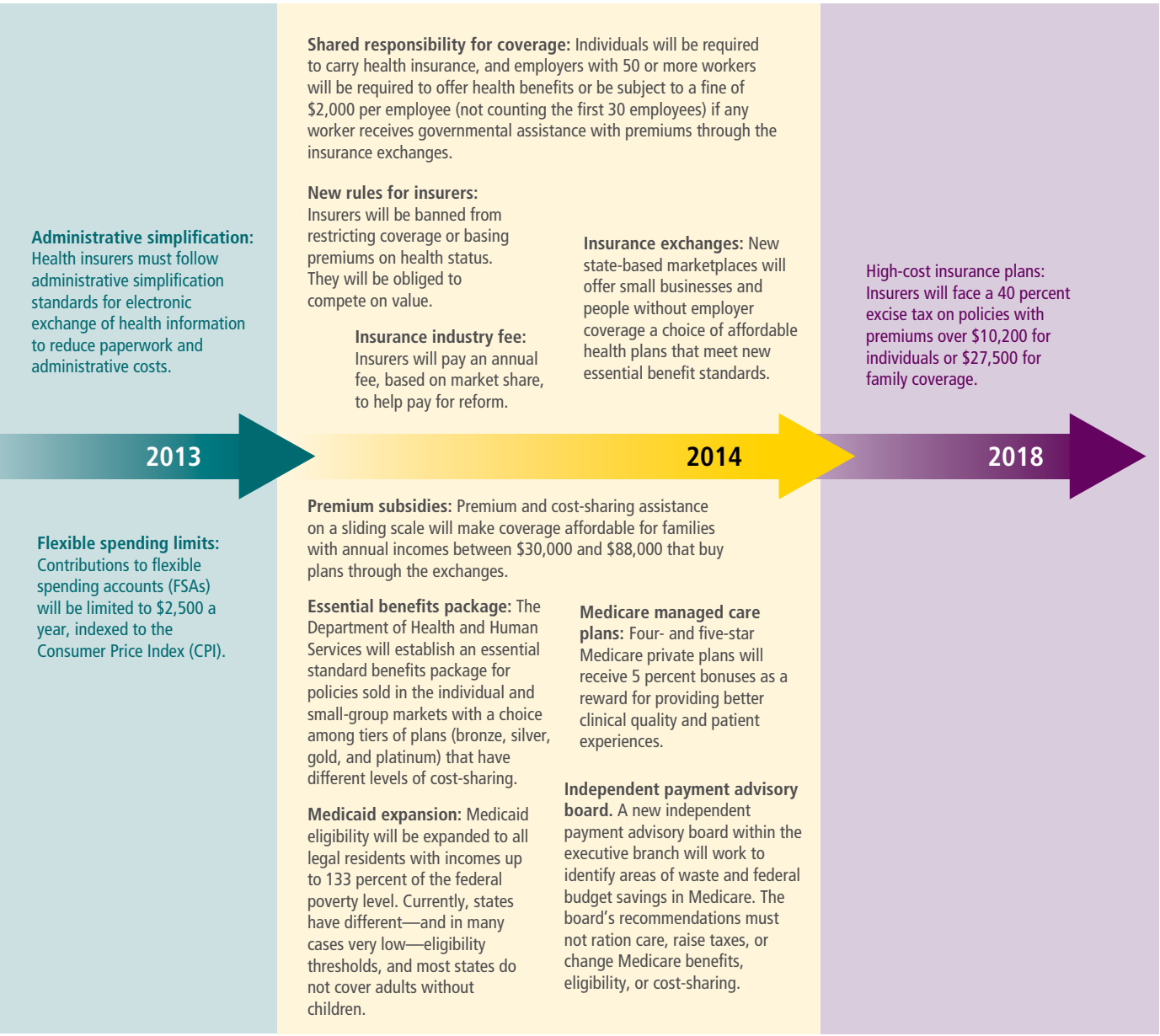
OTC drug reimbursement restrictions: Over-the-counter drugs not prescribed by a doctor will no longer be reimbursable through flexible spending arrangements or health savings/medical savings accounts.

CLASS Act: A national, voluntary insurance program for purchasing community living assistance services and support (CLASS) will be established. All working adults will be automatically enrolled—unless they opt out—through payroll deductions that, after five years, will qualify them for monthly payments toward services to help them stay at home should they become disabled.

Over the next decade, health reform will help all Americans—young, old, poor, middle-income, working, and unemployed—get and keep affordable health care coverage, while putting in place mechanisms to slow the growth in health care costs and improve quality. Following are key questions that journalists and others might have about how reform will change the way health care is paid for and delivered.

1 How will health reform help more people obtain coverage and access to care? Who will be helped?

Both health care coverage and access to care will be expanded under a mixed private–public system of health care financing.



The uninsured

By 2019, an additional 32 million uninsured will be covered, increasing the proportion of the population with insurance to 94 percent. Without health reform, the number of uninsured—now at 46 million—would have risen to an estimated 54 million by 2019. Instead that number will fall to 23 million, or about 6 percent of the population.

About 16 million uninsured people with incomes below 133 percent of the federal poverty level will be covered by Medicaid. They also may find a greater number of doctors who accept Medicaid, because Medicaid's often low reimbursement rates for primary care will be increased to the same level as Medicare's in 2013 and 2014.

In 2014, insurance plans will no longer be able to turn people away because of preexisting medical conditions. Nor will people with health conditions be charged higher premiums than healthy people. As a result, people in poor health who cannot work no longer have to fear being without access to coverage and care.

An estimated 24 million people will purchase coverage through new state-based health insurance exchanges. (In states that opt not to establish exchanges, the federal government will establish insurance exchanges instead.) Families with incomes between $30,000 and $88,000 a year will be eligible for premium subsidies for plans purchased through the exchanges. The subsidies would cap premium costs as a share of income at 3 percent for families earning

Major Features and Impacts of Health Reform

- **Individual mandate**
- **Employer shared responsibility**
- **Insurance market rules on enrollment, premiums, medical loss, consumer protections**
- **State or federal insurance marketplaces called "exchanges"**
- **Standard benefits package**
- **Income-related premium and cost subsidies ensure affordability**
- **Medicare prescription drug coverage gap—the "doughnut hole"—eliminated by 2020**
- **Coverage of uninsured: 32 million newly insured; 94% of legal residents insured**
- **Federal budget impact: $143 billion reduction in federal budget deficit over 10 years**
- **Health spending trends: annual national health growth of 6% instead of 6.6%; savings of $2,500 per family in 2019**

just over $30,000, rising with income to 9.5 percent for families earning $88,000. Out-of-pocket costs for direct medical expenses for families with incomes between about $22,000 and $55,000 would be reduced and ceilings established on maximum out-of-pocket expenses for families up to $88,000 in income.

The underinsured

The standard benefits package will help some 25 million working-age underinsured adults—those whose health care coverage does not protect them adequately from high medical expenses—and the 72 million adults overall who have difficulty paying their medical bills or medical debt. All plans sold to individuals through the insurance exchanges will have to cover all health services included in the standard benefits package. The package will help protect against high medical expenses, and federal premium subsidies will help ensure plan affordability for qualified families.

Individuals and families

For individuals and families, insurance will be easier to obtain and more affordable. Employer-sponsored insurance will remain the primary source of coverage for most families, covering about 56 percent to 60 percent of people under age 65 in 2019, roughly the same as now. The health insurance exchanges will offer choices of affordable plans with different levels of cost-sharing and premiums and a standard benefits package.

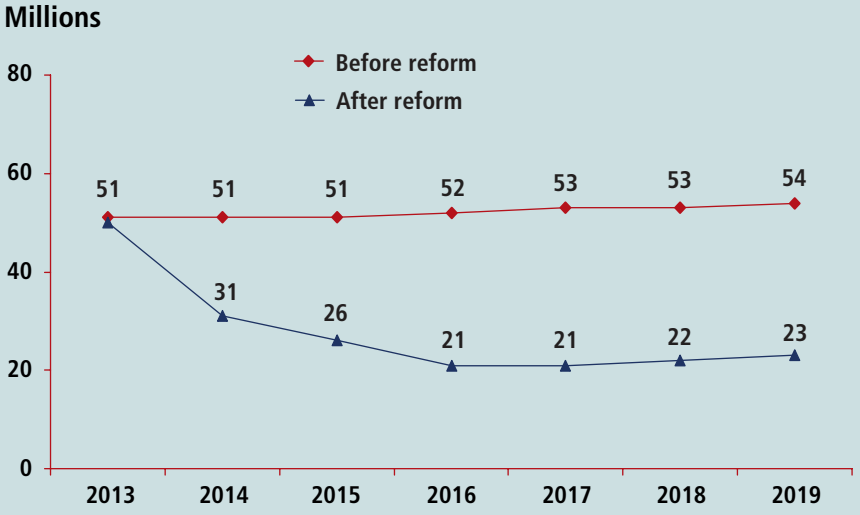
Small business and their workers

Currently, many small businesses cannot afford to offer health benefits. Those that do often must offer plans that have fewer benefits, charge higher premiums, and require higher levels of out-of-pocket spending. Consequently, people employed by small businesses often are uninsured or pay significantly more for coverage than those employed by larger businesses. Under reform, state insurance exchanges will ensure that individuals not covered by employers and small businesses with up to 50 to 100 employees will, at state discretion, have access to affordable coverage. The insurance exchanges will provide a stable source of affordable coverage for people who lose their jobs and their coverage. For small businesses that provide coverage, tax credits for two years will offset a portion of their costs.

Older adults

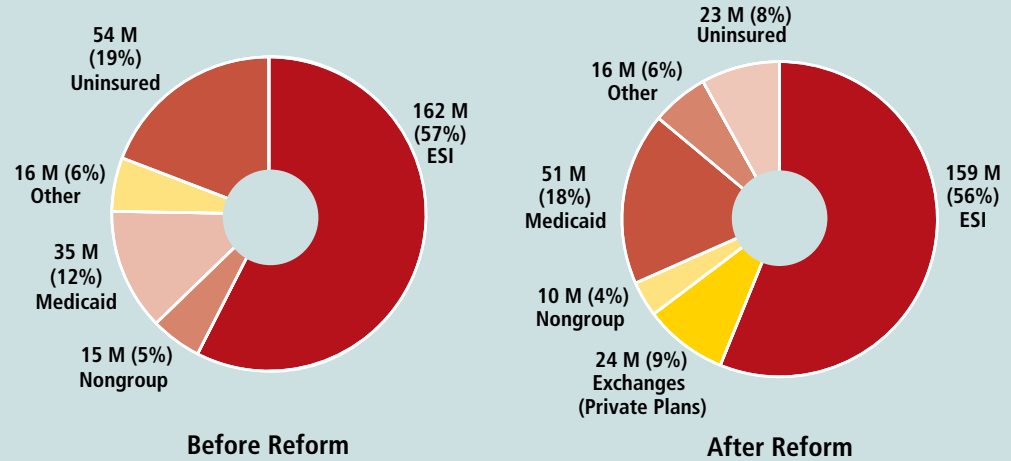
Older adults—those ages 50 to 64 and not yet eligible for Medicare—generally pay higher premiums in the individual market than younger people do, because they are considered higher risks. Similarly, insurance carriers charge higher premiums for small companies with older workforces. Premiums can vary by age by as much as 25 to 1 in the individual and small-group markets. Health reform places limits on insurers' ability to raise premiums based on age. Premiums will not be allowed to vary by more than 3 to 1. For example, if a 20-year-old whose income is too high for a premium subsidy pays $2,637 a year for the premium of a silver plan offered through the exchange, a 60-year-old might pay as much as $7,911 a year without a subsidy, but no more.

Trend in the Number of Uninsured Nonelderly, 2013–2019 Before and After Health Reform



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% of legal nonelderly residents are projected to have insurance under the new law.
Sources: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

Source of Insurance Coverage Before and After Health Reform, 2019



Among 282 million people under age 65

Notes: Employees whose employers provide coverage through the exchange are shown as covered by their employers (5 million), thus about 29 million people would be enrolled through plans in the exchange. ESI is employer-sponsored insurance.
Source: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

Seventy-Two Million Americans Have Problems with Medical Bills or Accrued Medical Debt, 2007

Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

Source: M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008).

Medicare beneficiaries

All beneficiaries will continue to be guaranteed all of Medicare's basic benefits. In fact, those benefits will be improved with expanded coverage for preventive care and reduced prescription drug costs. Preventive care will be free; beginning in 2011, beneficiaries will receive an annual wellness visit without a copayment. The Medicare Part D prescription drug coverage gap—informally known as the "doughnut hole"—will be phased out completely by 2020. Currently, the doughnut hole kicks in when beneficiaries exceed $2,830 in annual prescription drug claims, after which they must pay all drug costs until reaching $6,440, when Part D pays again. Increased assistance will be available to low-income beneficiaries.

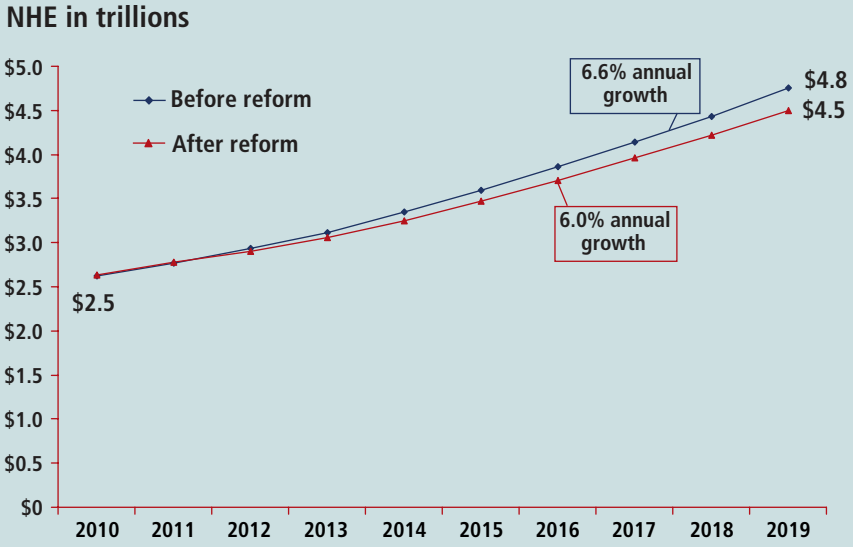
Young adults

Young adults ages 19 to 25 constitute 19 percent of the uninsured. Among those without insurance, two-thirds report problems getting access to care and half report problems with medical bills or debt. Beginning in September 2010, young people will be allowed to remain under their parents' coverage until age 26. Starting in 2014, Medicaid will be available to all adults with incomes at or below 133 percent of the federal poverty level. In addition, they will be able to buy coverage through insurance exchanges, where two-thirds of young adults (those with incomes below four times the poverty level) will receive help paying premiums and medical bills.

Children

Insurers will no longer be able to deny coverage to children with preexisting conditions. Reauthorization of the Children's Health Insurance Program (CHIP) will be extended through 2015 and federal matching funds for states will be increased, helping states to expand coverage.

Total National Health Expenditures, 2010–2019 Projections Before and After Health Reform



Sources: D. M. Cutler, K. Davis, and K. Stremikis, *Why Health Reform Will Bend the Cost Curve* (Washington and New York: Center for American Progress and The Commonwealth Fund, Dec. 2009).

2 What will happen to health care costs as a result of reform?

Growth in national health expenditures—currently $2.5 trillion annually—will slow, making premiums more affordable for employers and families, and easing fiscal pressures on government. Under reform, health care expenditures will grow an estimated 6 percent annually, compared with 6.6 percent as projected without reform. This may not seem like a big difference, but it is significant: In 2019, national health care expenditures are projected to be $4.5 trillion under reform, compared with an estimated $4.8 trillion without reform.

Families and individuals

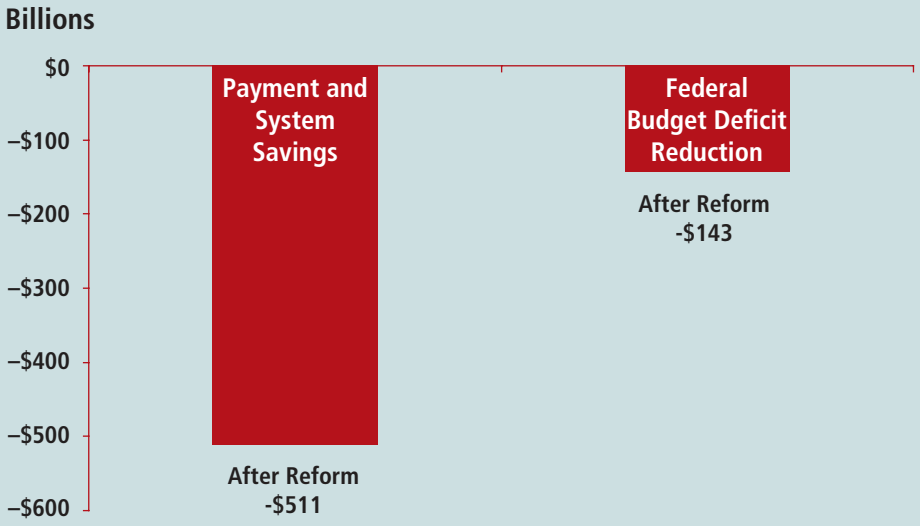
Families and individuals purchasing coverage through insurance exchanges will have greater protection against out-of-pocket costs than currently available in the individual and small-group markets. According to a Commonwealth Fund analysis, reform will save the average American family $2,500 in 2019. The Medicare Hospital Insurance payroll tax will increase by 0.9 percentage points for individuals with incomes over $200,000, or couples with incomes over $250,000, to help pay for health reform, and such households will also pay a 3.8 percent tax on unearned income.

Federal government

Reforming health insurance will cost the government an estimated $820 billion over 10 years. However, reform has been designed so that it does not increase the federal deficit. In fact, between 2010 and 2019, health reform is expected to save $511 billion and to reduce the federal budget deficit by $143 billion. All expansions of coverage, improvements in services, and financial protection for low- and moderate-income families are financed by payment and system reform measures that slow the growth in total health expenditures and in Medicare, and by new tax revenues. Among the most significant cost offsets:

- Overpayments to Medicare managed care plans that benefit insurance companies and a minority of beneficiaries at the expense of all Medicare beneficiaries will gradually be eliminated. The Congressional Budget Office (CBO) estimates that phase-out of these overpayments will save $204 billion from 2010 to 2019.

Estimated Net 2010–2019 Payment and System Savings and Federal Budget Deficit Reduction After Reform



Source: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

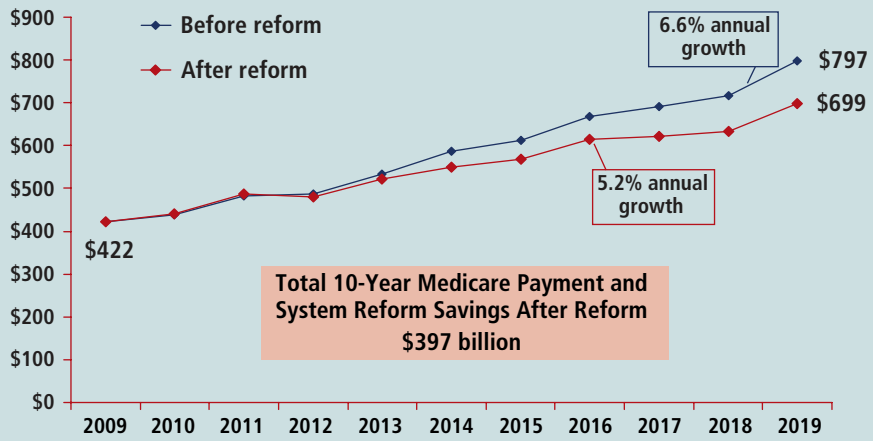
Payment and System Reform Provisions, Federal Budget Savings, 2010–2019

Dollars in billions

	CBO Estimate of Health Reform
Total Savings from Payment and System Reforms	**–$511**
• Productivity improvement/provider payment updates	–160
• Medicare Advantage reform	–204
• Primary care, geographic adjustment	6
• Payment innovations	–8
• Hospital readmissions	–7
• Disproportionate share hospital adjustment	–36
• Prescription drugs	29
• Home health	–40
• Independent Payment Advisory Board	–16
• Comparative effectiveness research and benefit design	—
• Other improvements and interactions	–75

Source: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

Medicare Spending, 2010–2019: Before and After Health Reform



Sources: D. M. Cutler, K. Davis, and K. Stremikis, *Why Health Reform Will Bend the Cost Curve*, (Washington and New York: Center for American Progress and The Commonwealth Fund, Dec. 2009); and The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

- Medicare payments to providers will be adjusted for improvements in productivity. These adjustments will cover payments to inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. CBO projects savings of $160 billion through these adjustments from 2010 to 2019.
- As the number of uninsured falls, Medicare and Medicaid's disproportionate share payments to hospitals will decrease to reflect lower uncompensated care costs. CBO estimates savings of $36 billion over 10 years from these adjustments.
- The increase in the Medicare Hospital Insurance tax paid by high-income earners will raise an estimated $210 billion over 2012–2019.
- New annual fees paid by insurers will yield an estimated $60.1 billion over 2014–2019.
- New annual fees on pharmaceutical manufacturers will raise an estimated total of $27 billion over 2011–2019.
- A 2.9 percent excise tax on medical device manufacturers will yield an expected $20 billion over 2013–2019.
- An excise tax on high-cost insurance plans will raise an estimated $32 billion over 2018–2019.

Under reform, Medicare spending growth will be slowed from projected increases of 6.6 percent to 5.2 percent. In this way, health reform will extend the solvency of the Medicare trust fund through 2026 and save $397 billion from 2010 to 2019.

While the projected 69 percent growth under reform will be significantly lower than projected prior to reform—89 percent—even this reduction is greater than projected growth in the rest of the U.S. economy: The Gross Domestic Product (GDP) will increase an estimated 63 percent between 2009 and 2019.

Business

Businesses of all sizes stand to gain under reform, though costs will increase initially for employers that do not currently shoulder some responsibility for providing coverage. Rises in premiums will slow, yielding substantial savings to employers over time.

In addition, tax credits and subsidies will be available for small businesses that contribute to their employees' premiums. For firms with 10 employees or fewer and average wages below $25,000 that contribute 50 percent of their employees' premiums, the new law will provide tax credits for up to two years. These credits will be phased out for firms with up to 25 employees and average wages

of $50,000. From 2010 to 2013, the law provides for tax credits worth up to 35 percent of premium contributions; beginning in 2014, the credits will be worth 50 percent of the contribution. For example, a company that is eligible for the full credit and contributes 50 percent of a family premium for a silver plan offered through the exchange would be eligible for a credit of $1,651 per worker in the first two years, according to a Commonwealth Fund analysis, leaving it with a balance of $3,067. After 2014, that company would receive a credit of $2,359 per worker, for a balance of $2,359.

3 How will people's health insurance choices be affected?

Health insurance choices will expand under health reform. New health insurance exchanges will give eligible individuals and businesses choices of affordable health plans, including private plans, nonprofit cooperative plans, and multistate private plans. These plans will offer an essential health benefits package without lifetime or annual limits. Four benefit categories—bronze, silver, gold, and platinum, with different levels of price-sharing—will be established. Health insurers will not be permitted to cancel a policy if a person becomes sick.

Four Benefit Categories Under Essential Benefits Package

- **Bronze:** Covers 60% of enrollees' medical costs, with out-of-pocket spending limited to what is defined for health savings accounts (HSAs) or $5,950 for individual policies and $11,900 for family policies.
- **Silver:** Covers 70% of medical costs with same out-of-pocket limits.
- **Gold:** Covers 80% of medical costs with same out-of-pocket limits.
- **Platinum:** Covers 90% of medical costs with same-out-of-pocket limits.

All benefit categories will have the essential benefits package. Policies may be sold in small-group and individual markets or exchanges that do not meet actuarial standards for the benefit categories established by law. All carriers selling in the individual and small-group markets are required to offer at least the silver and gold plans.

4 How will health care delivery change as a result of health care reform?

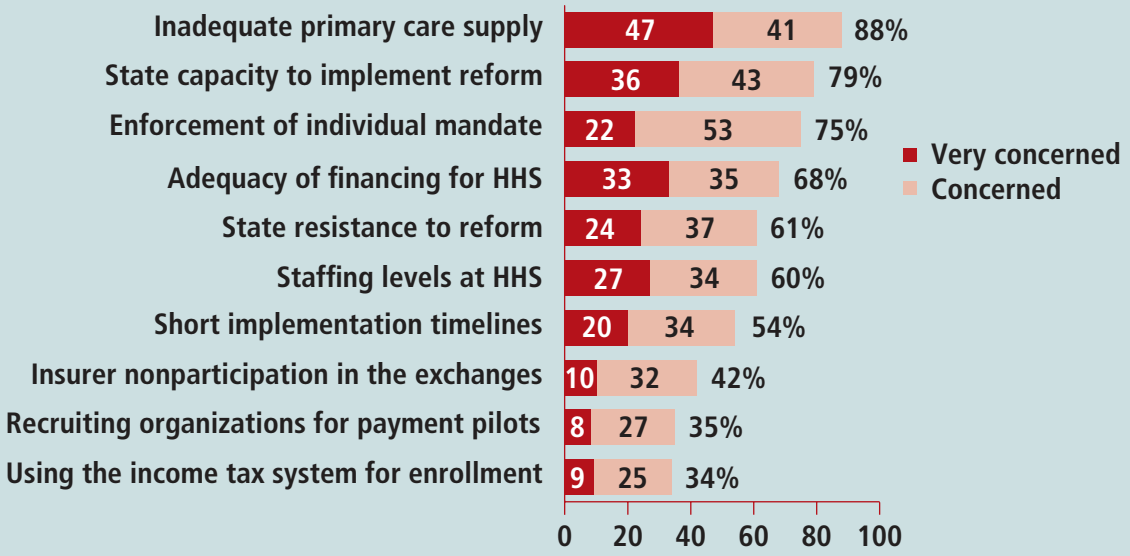
Health reform will increase investments in primary care while testing innovative payment methods designed to reward high quality and value. The creation of a Center for Medicare and Medicaid Innovation will provide a platform for developing new approaches to paying for health care to encourage greater quality and efficiency. Currently, providers are paid more for providing more services, more complicated procedures, and more expensive care. The long-run viability of the health care system depends on paying for and providing care in a way that yields value for the resources spent.

For example, instead of paying providers according to the current fee-for-service model, Medicare and other payers may pay according to how well providers manage the care and health of their patients with chronic illnesses, like diabetes. Or they may start "bundling" payments for hospital procedures—instead of separate payments to hospitals and doctors involved in a patient's care, a single reimbursement would cover an entire hospital stay for a medical procedure.

Under these payment approaches, providers demonstrating superior patient outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative, or avoidable services may not fare as well, and might strive to improve their care.

Health Care Opinion Leader Views of Implementation Issues

"Assuming a comprehensive health reform bill reaches the President's desk, how much of a concern are the following implementation issues?"



Note: Percentages may not add to total because of rounding.
Source: K. Stremikis, K. Davis, and R. Nuzum, *Health Care Opinion Leaders' Views on Health Reform, Implementation, and Post-Reform Priorities*, (New York: The Commonwealth Fund, April 2010).

5 What else needs to be done?

Despite significant advances under reform, the U.S. health system is unlikely to reach its potential without more far-reaching measures in the coming years. Most important, an estimated 15 million legal residents will remain uninsured—including many exempt from the requirement to carry coverage because of their incomes. Subsidies for low-income families and small firms may need to be expanded to cover the remaining uninsured. And while Medicare will explore payment reforms to make health care more effective and more efficient, private sector payers will need to change their payment methods too.

There are also very real, immediate challenges related to implementation of current reforms. For example:

- How will the temporary high-risk pool for people with preexisting conditions work?
- What will happen to people who lose their jobs between now and 2014, when expanded coverage begins? The final reform law does nothing to extend government-mandated COBRA benefits, which currently expire after 18 months.
- How will the nation's safety net of public hospitals and community clinics be sustained and restructured under health reform?
- What else needs to be done to ensure a strong primary care system that prevents acute illness, manages chronic illness, and coordinates care among providers?
- What are the states' capacities for implementing reform? How many will establish new insurance exchanges and expand their Medicaid programs?

Sources

The following Commonwealth Fund publications are available at www.commonwealthfund.org.

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Additional source

The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, March 20, 2010, http://www.cbo.gov/doc.cfm?index=11379.

Conclusion

Health reform will fundamentally alter our present course of rising costs and increasing numbers of uninsured and underinsured. The new law represents a pragmatic approach to closing gaps in insurance coverage, building on a mix of employer coverage and private plans in health insurance exchanges, retention of Medicare, and expansion of Medicaid. It will lay the foundation for a high performance health system affording access to care for all, improved quality, and greater efficiency.

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