Resources to Understand and Track Health Care Reform

The Robert Wood Johnson Foundation

http://www.rwjf.org/healthreform/

Also from RWJF: Health Reform GPS – tracking implementation

http://www.healthreformgps.org

The Henry J. Kaiser Family Foundation

http://healthreform.kff.org/

U.S. Congress

http://www.speaker.gov/newsroom/legislation?id=0361

The White House

http://www.whitehouse.gov/issues/health-care

U.S. Department of Health and Human Services

http://www.hhs.gov/ [see esp. "News" tab]

Washington Legislature Joint Select Committee on Health Reform Implementation

http://www.leg.wa.gov/JointCommittees/HRI/Pages/default.aspx

Washington State Office of the Governor

http://www.governor.wa.gov/priorities/healthcare/reform.asp

Washington State Office of the Insurance Commissioner

http://www.insurance.wa.gov/consumers/reform/national_health_care_reform.shtml

The Health Retort (Aaron Katz's blog)

http://blog.seattlepi.com/thehealthretort/

Center for Studying Health System Change

http://www.hschange.com/

The Hearndon Alliance

http://www.herndonalliance.org/

The Health Policy Hub (Community Catalyst blog)

http://blog.communitycatalyst.org/

Summary of the Health Reform Legislation

Adapted from: *Health Reform GPS, www.healthreformgps.org, from the Robert Wood Johnson Foundation and George Washington University School of Public Health & Health Services; Kaiser Family Foundation, www.healthreform.kff.org; and The Health Retort at the Seattle PI, blog.seattlepi.com/thehealthretort.*

The intent of the Patient Protection and Affordable Care Act is to expand health insurance coverage while also improving health care quality and value. It also includes provisions to reduce disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce, and encourage patient wellness. According to the Congressional Budget Office, the law will increase coverage to about 94 percent of Americans, while slowing the rate of growth in federal health expenditures by $124 billion over the next decade.

Immediate Reforms

Many significant reforms will not take effect until 2014, but some provisions start in 2010-11.

Immediate measures addressing high health costs and lack of insurance:

- Provides $5 billion for temporary "high risk" insurance pools for adults who cannot get insurance because of a pre-existing condition (who have been uninsured for six months and can't find affordable coverage).
- Requires insurers to allow parents to keep children on their insurance up to age 26.
- Provides tax credits to small businesses to help lower the cost of providing health insurance to their employees.
- Provides temporary assistance to employers to help lower the cost of providing coverage to certain high-cost retirees between the ages of 55 and 64.
- Provides a $250 rebate for the Medicare prescription drug coverage gap ("donut hole").
- Establishes an Internet portal to help individuals and small businesses find affordable health insurance options and learn about other programs such as Medicaid and the Children's Health Insurance Program (CHIP).

Immediate insurance reforms:

- Prohibits pre-existing condition exclusions for children's coverage.
- Prohibits lifetime limits on insurance policies, and restricts annual benefit limits.
- Prohibits insurers from rescinding polices except for fraud or intentional misrepresentation, and requires advance notice of rescissions.
- Requires appeal processes for denials, reductions, or delays of coverage or treatment.
- Requires insurers to spend at least 85 cents of every premium dollar on health services in the large group market, and 80 cents in the small group/individual market.
- Assists the Secretary of HHS and the states in conducting an annual review of health insurance premium increases and evaluating whether these increases are justified.

Longer Term: Changes to the Insurance Marketplace (2014)

How it works: Establishes new state "health insurance exchanges," where small businesses and people who do not get insurance from an employer will be able to buy insurance. All insurers that participate in the insurance exchanges must provide a package of "essential benefits" in order to help consumers compare policies and ensure that important benefits are

not omitted. In addition to four benefit "tiers," a catastrophic benefit package will be available for people under age 30 and others who are unable to find affordable coverage.

What it means for individuals:

- All individuals will be required to carry insurance or pay a tax. (Enrollment in federal programs is considered insurance - Medicare, Medicaid, Children's Health Insurance Program, TriCare, federal employee and veterans' health plans, Indian Health Service).
- Individuals and families earning less than 400% of the federal poverty level (e.g. $73,240 for a family of three in 2010) will receive tax credits to subsidize insurance premiums, and may also be eligible for help with out-of-pocket costs. (See page 5, "How do the tax credits work?") Individuals can be exempted from the health insurance requirement if the cost of coverage exceeds a certain percentage of their income.
- Undocumented immigrants will be barred from buying coverage through the exchanges and from receiving tax credits.

What it means for businesses:

- Provides tax credits to small businesses to make it more affordable to offer insurance to employees and their families.
- For employers with 50+ employees: If they do *not* offer coverage, they will pay a fee for each of their employees who must rely on tax credits to buy insurance through the insurance exchange. For employers with 200+ employees: If they *do* offer insurance, they must automatically enroll employees in the plans, while permitting employees to opt out.

Additional insurance reforms:

- Insurers will no longer be able to discriminate based on health status or gender; impose waiting periods of more than 90 days; cap benefits; or rescind coverage retroactively.
- Insurers must offer certain wellness and preventive services at no out-of-pocket cost.
- Requires that mental health and addiction services be covered on an equal footing with other medical coverage.

Abortion provisions: Maintains current laws that prohibit use of federal funds to pay for abortion services other than in cases of rape, incest, and procedures needed to save the life of the mother. Individuals purchasing coverage through a state exchange will be able to buy coverage for other abortion services with their own funds (unless prohibited by state law).

Expand Public Insurance for Low-Income People

- Extends the Children's Health Insurance Program (for low-income kids) through 2015.
- Expands Medicaid to non-elderly low-income people with incomes up to 133% of the federal poverty level (e.g. $24,352 for a family of three in 2010). (Up from 100% of FPL)
- Provides financial assistance to states for the cost of insuring these new enrollees, and for increased reimbursement rates to primary care providers.
- Permits states to provide family planning services to certain low-income women who are not eligible for Medicaid.

Medicare Changes

- Phases in full coverage of prescription drugs under Medicare Part D, eliminating the current gap in coverage known as the "donut hole."
- Expands Medicare coverage of preventive services, and eliminates copayments and deductibles for these services.

- Reduces subsidies for private managed care programs in Medicare.

Long-Term Care

- Creates new Medicaid options to promote community-based long-term care and protect spouses of those with serious illness from becoming impoverished.
- Creates a voluntary long-term care insurance program.

Other Tax Changes

- Limits the amount that can be set aside by individuals in tax-preferred accounts, known as cafeteria plans, and increases penalties for early withdrawals or withdrawals for non-health purposes from Health Savings Accounts and Medical Savings Accounts.
- Increases the threshold for deduction of medical expenses from 7.5 to 10 percent.
- Increases Medicare payroll taxes for high-income individuals.

Efforts to Improve Health Care Quality and Value

A core purpose of the health reform law is to advance innovations, technology, and other tools that have been shown to improve quality and reduce unnecessary spending.

- Establishes two new research bodies to recommend new or more effective approaches to health care delivery: the Center for Medicare and Medicaid Innovation, and the Patient-Centered Outcomes Research Institute.
- Authorizes reforms and pilot programs to test alternative service delivery and payment systems in Medicare and Medicaid.
- Strengthens anti-fraud and abuse safeguards in Medicare and Medicaid.
- Imposes a surtax on “high-cost” health insurance plans, to encourage individuals and employers to choose lower-cost health insurance plans.
- Authorizes states to test and evaluate alternatives to medical malpractice litigation in order to promote faster and cheaper dispute resolution.

Investment in the Public Health and Health Care Infrastructure

- Establishes a council to develop prevention, wellness and health promotion goals and to develop a national disease prevention strategy.
- Funds and promotes a range of public health, disease prevention, school-based health, preventive dental, maternal and child health, and workplace wellness programs.
- As more people have insurance, there will be a need for more medical providers, particularly in primary care. The law revises medical residency training programs to emphasize primary care; invests in scholarships and loan repayment assistance for the health care workforce, and grants to promote diversity in the health care workforce.
- Strengthens and expands Community Health Centers, the National Health Service Corps, and the Indian Health Service.
- Adjusts Medicaid and Medicare payments for health care providers serving heavily rural or indigent populations.
- Requires national nutrition labeling information be available in restaurants.
- Improves data collection and reporting designed to understand and reduce health disparities based on race, ethnicity, gender and disability.

How do the tax credits work?

Under the health reform act, people purchasing coverage on their own through the insurance exchanges (where individuals and businesses will buy insurance) are eligible for tax credits based on income. The tax credit is based on the premise that you should not have to pay more than a certain percentage of your income in order to get a baseline level of health coverage.

Step 1: Are you eligible for a tax credit? Citizens and legal residents with incomes between 133% and 400% of the *Federal Poverty Level* (FPL) are eligible for the tax credit.

Family size:	FPL	Eligible for credits between…	…and
1	$10,830	$14,404	$43,320
2	$14,570	$19,378	$58,280
3	$18,310	$24,352	$73,240
4	$22,050	$29,327	$88,200
5	$25,790	$34,301	$103,160

Step 2: Figure out your income relative to the Federal Poverty Level.

Divide:	Your income / FPL for your family size		Multiply by 100	= your income as a percent of FPL
Example: For family of 2 making $36,000	*$36,000 / $14,570*	*= 2.47*	*= 247*	*247% of FPL*

Step 3: What's your premium "baseline?" In the insurance exchanges, insurers must offer four tiers of benefits – Bronze, Silver, Gold and Platinum. The "baseline" for calculating tax credits is the *second-cheapest Silver Plan* offered in your exchange –the law says that premiums for this level of coverage shouldn't cost more than a certain percentage of your income.

So if your income is…	Your "baseline" coverage premium shouldn't exceed:
133% to 150% of FPL	3% to 4% of your income
150% to 200%	4 % to 6.3% of your income
200% to 250%	6.3% to 8.05% of your income
250% to 300%	8.05% to 9.5% of your income
300% to 400%	9.5% of your income

Step 4: What's the tax credit? It's the difference between what you actually pay for insurance on the exchange – regardless of what plan you actually buy – and this "baseline" premium calculation. So for our example family of two, making $36,000 at ~250% of FPL:

- The most they should have to pay for the second-cheapest Silver Plan is 8.05% of their income, or $3,060/year
- If they buy the second-cheapest Silver plan, and it actually costs $4,000 – they will get a tax credit for the difference. Pay $4,000, get $940 tax credit, so out-of-pocket is $3,060
- If they decide to buy the better Gold plan instead – say that costs $6,000 - they will get the same tax credit: Pay $6,000, get $940 tax credit, so out-of-pocket is $5,060

For more information: On-line calculators:

- For individual/family credits: http://healthreform.kff.org/Subsidycalculator.aspx
- For small business credits: http://www.smallbusinessmajority.org/tax-credit-calculator/

March 2010

The Benefits of Health Care Reform In the 7th Congressional District of Washington

Committee on Energy and Commerce

The U.S. House of Representatives will soon vote on health care reform legislation. This legislation will make health care affordable for the middle class, provide security for seniors, and guarantee access to health insurance for the uninsured – while reducing the federal deficit by over $100 billion over the next decade. This analysis examines the benefits of the legislation in the 7th Congressional District of Washington, which is represented by Rep. Jim McDermott.

In Rep. McDermott's district, the health care reform bill will:

- Improve coverage for **479,000** residents with health insurance.
- Give tax credits and other assistance to up to **157,000** families and **21,300** small businesses to help them afford coverage.
- Improve Medicare for **84,000** beneficiaries, including closing the donut hole.
- Extend coverage to **25,000** uninsured residents.
- Guarantee that **8,900** residents with pre-existing conditions can obtain coverage.
- Protect **800** families from bankruptcy due to unaffordable health care costs.
- Allow **61,000** young adults to obtain coverage on their parents' insurance plans.
- Provide millions of dollars in new funding for **49** community health centers.
- Reduce the cost of uncompensated care for hospitals and other health care providers by **$46 million** annually.

Affordable High-Quality Health Care for the Middle Class

Essential health insurance reforms. Approximately 72% of the district (479,000 residents) receives health care coverage from an employer or through policies purchased on the individual market. Under the legislation, individuals with insurance can keep the coverage they have now, and it will get better. The insurance reforms in the bill prohibit annual and lifetime limits, eliminate rescissions for individuals who become ill while insured, ban coverage denials for pre-existing conditions, and reduce the cost of preventive care. To rein in soaring insurance costs, the reforms also limit the amount insurance companies can spend on administrative expenses, profits, and other overhead.

Historic health care tax cuts. Those who do not receive health care coverage through their employer will be able to purchase coverage at group rates through the new health insurance exchange. To make this insurance affordable, the legislation contains the largest middle-class tax cut for health care in history, providing middle class families with incomes up to $88,000 for a family of four with tax credits to help pay for coverage in the exchange. For a family of four making $50,000, the average tax credit will be approximately $5,800. There are 157,000 households in the district that could qualify for these credits if they purchase health insurance through the exchange or, in the case of households with incomes below 133% of poverty, receive coverage through Medicaid.

Coverage for individuals with pre-existing conditions. There are 8,900 uninsured individuals in the district who have pre-existing medical conditions like cancer, heart disease, and diabetes. Under the bill's insurance reforms, they cannot be denied affordable coverage.

Financial security for families. There were 800 health care-related bankruptcies in the district in 2008, caused primarily by the health care costs not covered by insurance. The bill caps annual out-of-pocket costs at $6,200 for individuals and $12,400 for families who purchase insurance through the exchange or who are insured by small businesses. It also eliminates annual and lifetime limits on all insurance coverage. These reforms ensure that no family will have to face financial ruin because of high health care costs.

Security for Seniors

Improving Medicare. There are 84,000 Medicare beneficiaries in the district. The legislation improves their benefits by providing free preventive and wellness care, improving primary and coordinated care, and enhancing nursing home care. The bill also strengthens the Medicare Trust Fund, extending its solvency from 2017 to 2026.

Closing the Part D donut hole. Each year, 6,700 Medicare beneficiaries in the district enter the Part D donut hole and are forced to pay the full cost of their prescription drugs. Under the bill, these beneficiaries will receive a $250 rebate in 2010, 50% discounts on brand name drugs beginning in 2011, and complete closure of the donut hole within a decade. A typical beneficiary who enters the donut hole will see savings of over $700 in 2011 and over $3,000 by 2020.

New Coverage Options for Young Adults

New lower-cost health care options for young adults. The legislation will allow young adults to remain on their parents' policies until they turn 26. There are 61,000 young adults in the district who could benefit from this option. For individuals under age 30, the bill creates new, inexpensive policies that allow them to obtain protection from catastrophic health care costs.

Helping Small Businesses

Helping small businesses obtain health insurance. Under the legislation, small businesses with 100 employees or less will be able to join the health insurance exchange, benefiting from group rates and a greater choice of insurers. There are 23,400 small businesses in the district that could benefit from this provision.

Tax credits for small businesses. Small businesses with 25 employees or less and average wages of less than $50,000 will qualify for tax credits of up to 50% of the costs of providing health insurance. There are up to 21,300 small businesses in the district that could qualify for these credits.

Covering the Uninsured

Coverage of the uninsured. The legislation would extend coverage to 94% of all Americans. If this level of coverage is reached in the district, 25,000 residents who currently do not have health insurance will receive coverage.

Relieving the burden of uncompensated care. In 2008, health care providers in the district provided uncompensated care to individuals who lacked insurance coverage and were unable to pay their bills. Under the legislation, these costs of uncompensated care will be reduced by $46 million.

Supporting community health centers. There are 49 community health centers in the district that provide health care to the poor and medically underserved. Nationwide, the legislation would provide $11 billion in new funding for these centers. If the community health centers in the district receive the average level of support, the 49 centers will receive $63.7 million in new assistance.

Deficit Responsibility

No deficit spending. The cost of health care reform under the legislation is fully paid for, in large part by eliminating waste, fraud, abuse, and excessive profits for private insurers. The legislation will reduce the deficit by $130 billion over the next ten years, and by about $1.2 trillion over the second decade.

This analysis is based upon the following sources: the U.S. Census (data on insurance rates, small businesses, and young adult population); the Centers for Medicare and Medicaid Services (data on Medicare and Part D enrollment); the Department of Health and Human Services (data on health care-related bankruptcies, uncompensated care, and pre-existing conditions); the Health Resources and Services Administration (data on community health centers); and the Congressional Budget Office (estimates of the percentage of citizens with health insurance coverage under health care reform legislation).