

# **HEALTH CARE REFORM: Now that it's passed, what does it mean?**

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# Today's Topics

- The Patient Protection and Affordable Care Act (PPACA)
- Why did we spend so much time on reforming health care in US
- Near term policies (fall 2010)
- Longer term policies (2014 and beyond)
- Implications for seniors (esp. Medicare)

# The Patient Protection and Affordable Care Act (PPACA)

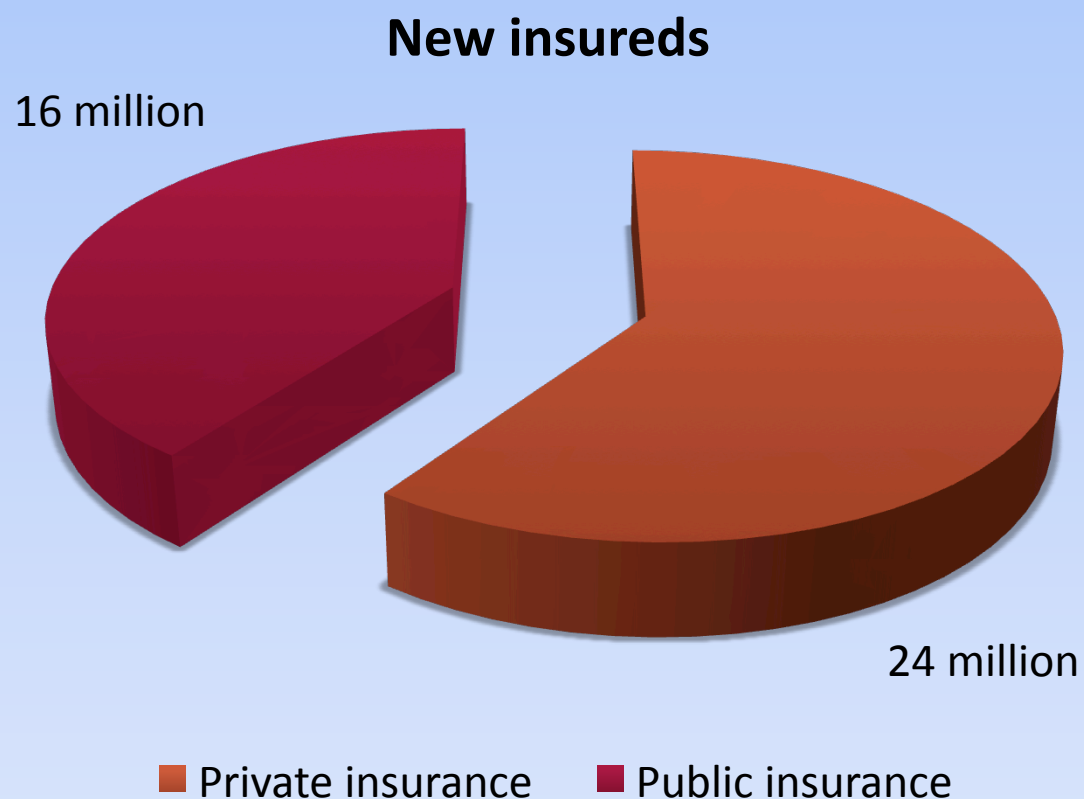
- Signed into law March 2010
- Emphasis on:
  - Individual insurance market
  - Small business insurance market
- Few implications for large employer-based insurance
  - Already self-insured

# Market-based reform

- Right of center approach to reform:  
Similar to proposals by Richard Nixon,  
Robert Dole and Mitt Romney  
Left of center approach-single payer
- Uses primarily private insurance  
companies:  
Some Gov't program expansion

## Coverage in new plan

- Net 32 million more insured
- Decline of 3 million from employers
- Decline of 5 million from non-group



# Cost of reform

- Total cost: \$940 billion first ten years
- Impact on deficit:
  - \$124 Billion in reductions in the deficit first ten years
  - \$1.2 Trillion second ten years

Source: Congressional Budget Office, March 2010

# Payment for reform

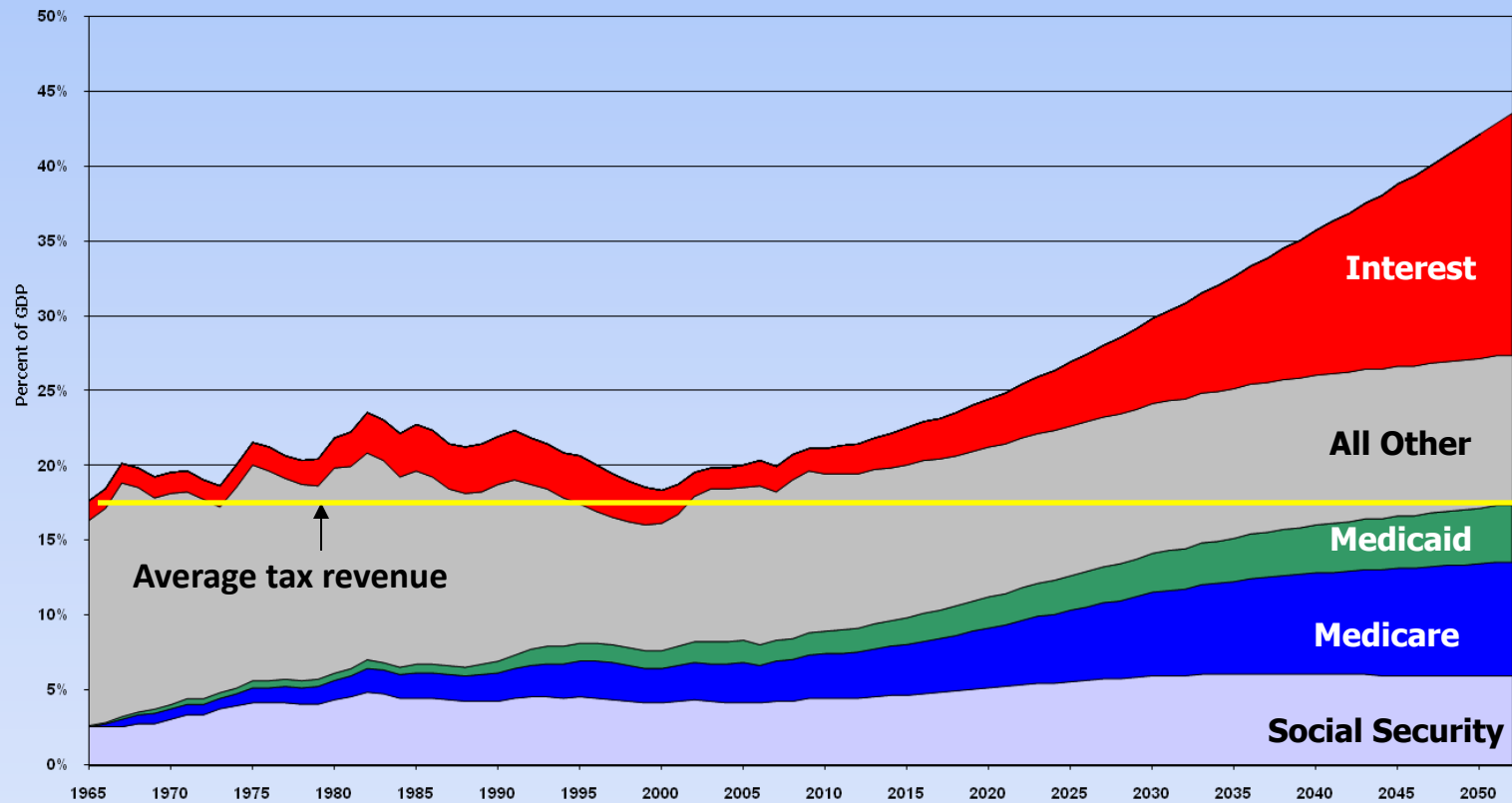
- Medicare payroll tax on investments (2012):  
3.8% on investment income for families > \$250,000
- Excise tax on investments (2019):  
40% on “Cadillac” plans
- Tanning tax (2010):  
10% on indoor services

Source: Congressional Budget Office, March 2010

# Why Reform Health Care in US

- Cost
- Access to Care – right vs. privilege
- Quality

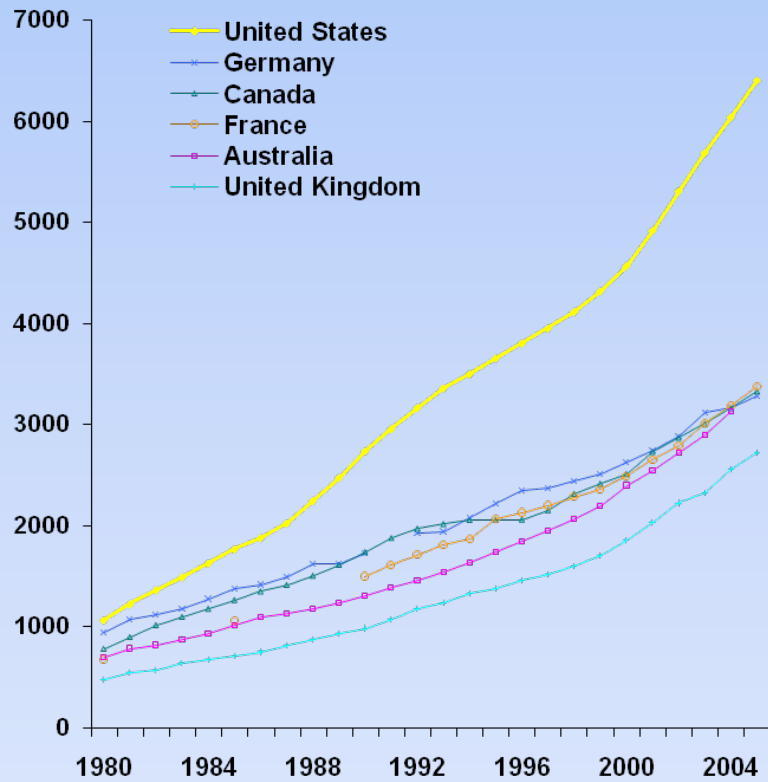
# Health Care Costs



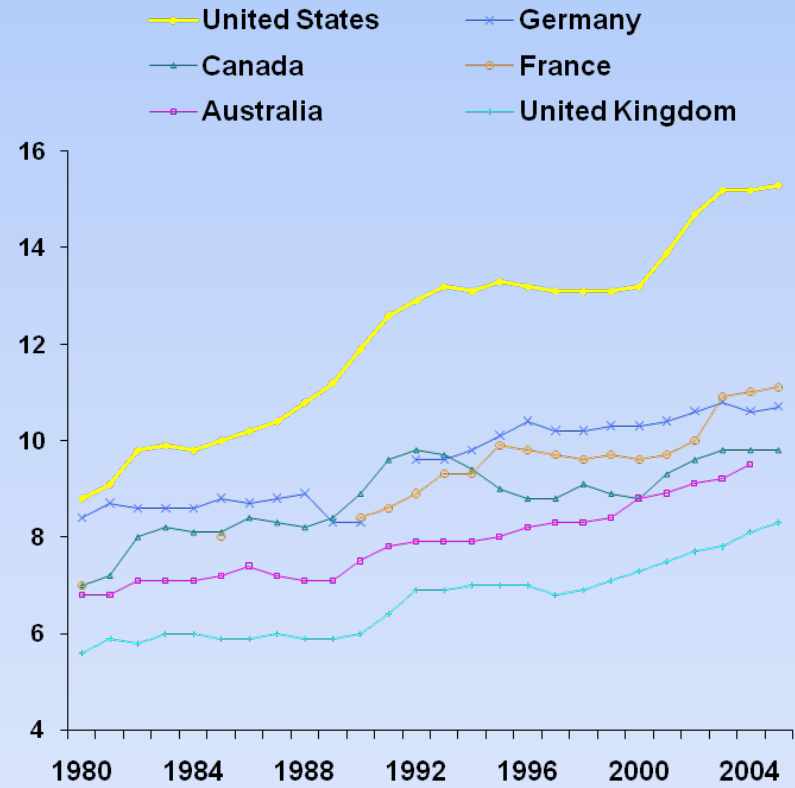
Source: Government Accountability Office, September 2008

# Health Care Costs

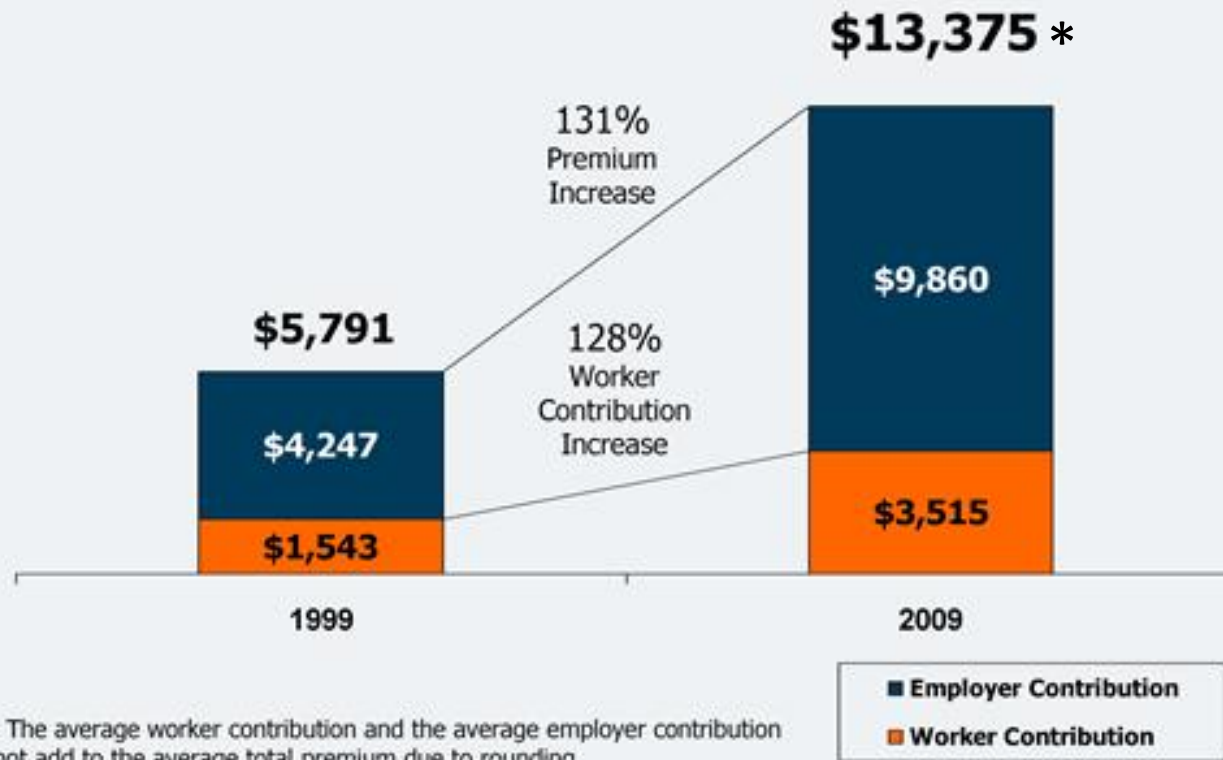
Average spending on health per capita (\$US )



Total health expenditures as percent of GDP



## Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.



\*Cost estimated to be \$28,500 in 2019

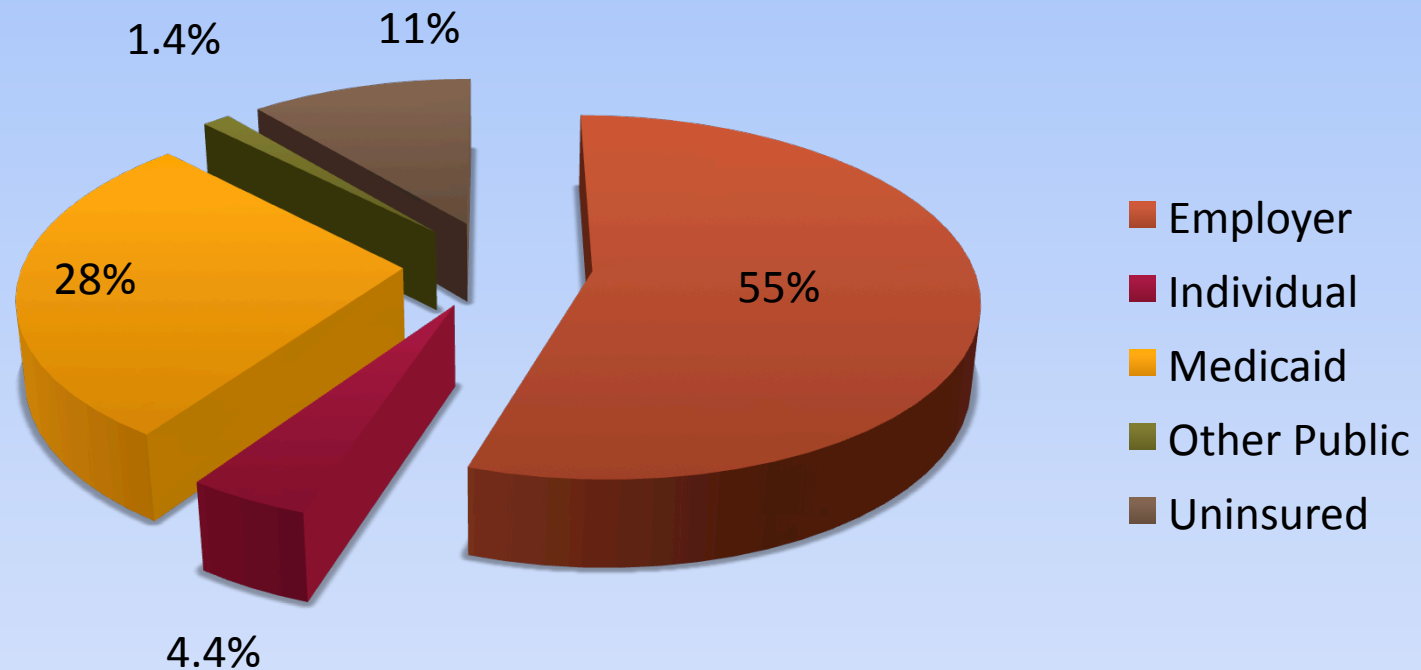
# Access to care

Financial



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## Health insurance

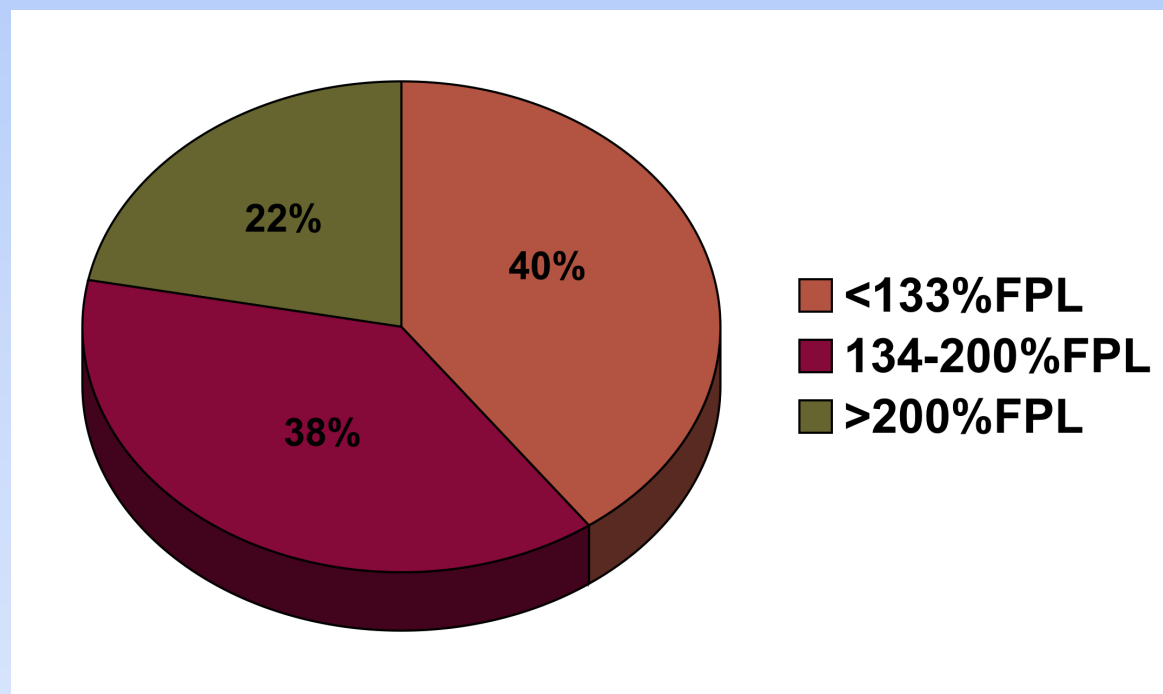


## Child Insurance Coverage in US, 2007

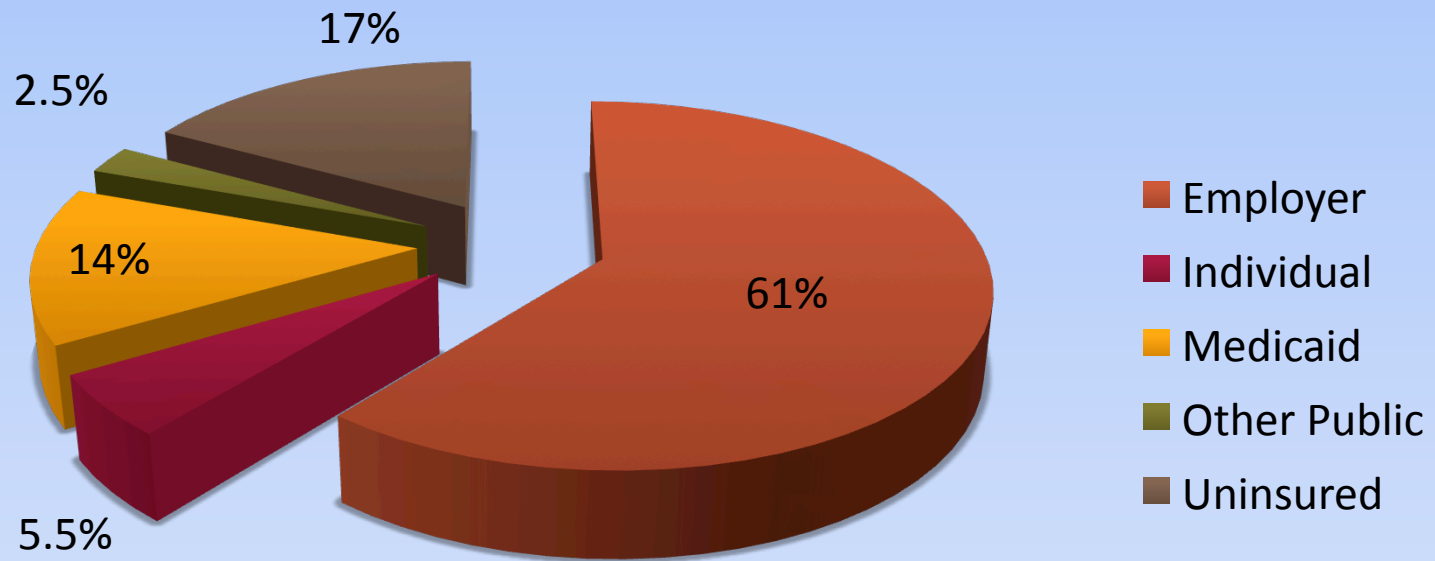
# Uninsured children in Iowa

3/4 of uninsured children are eligible for Medicaid/*hawk-i*

- 99% of children in Iowa covered if up to 300% FPL enrolled



## Health insurance



## Adult Insurance Coverage in US, 2007

# Uninsured Adults-Iowa

- 9-11% of all adults
- 81% of uninsured were employed  
5% unemployed
- 2/3 were without insurance for more than a year  
20% for 10 years or more
- 3/4 reported in good or excellent health



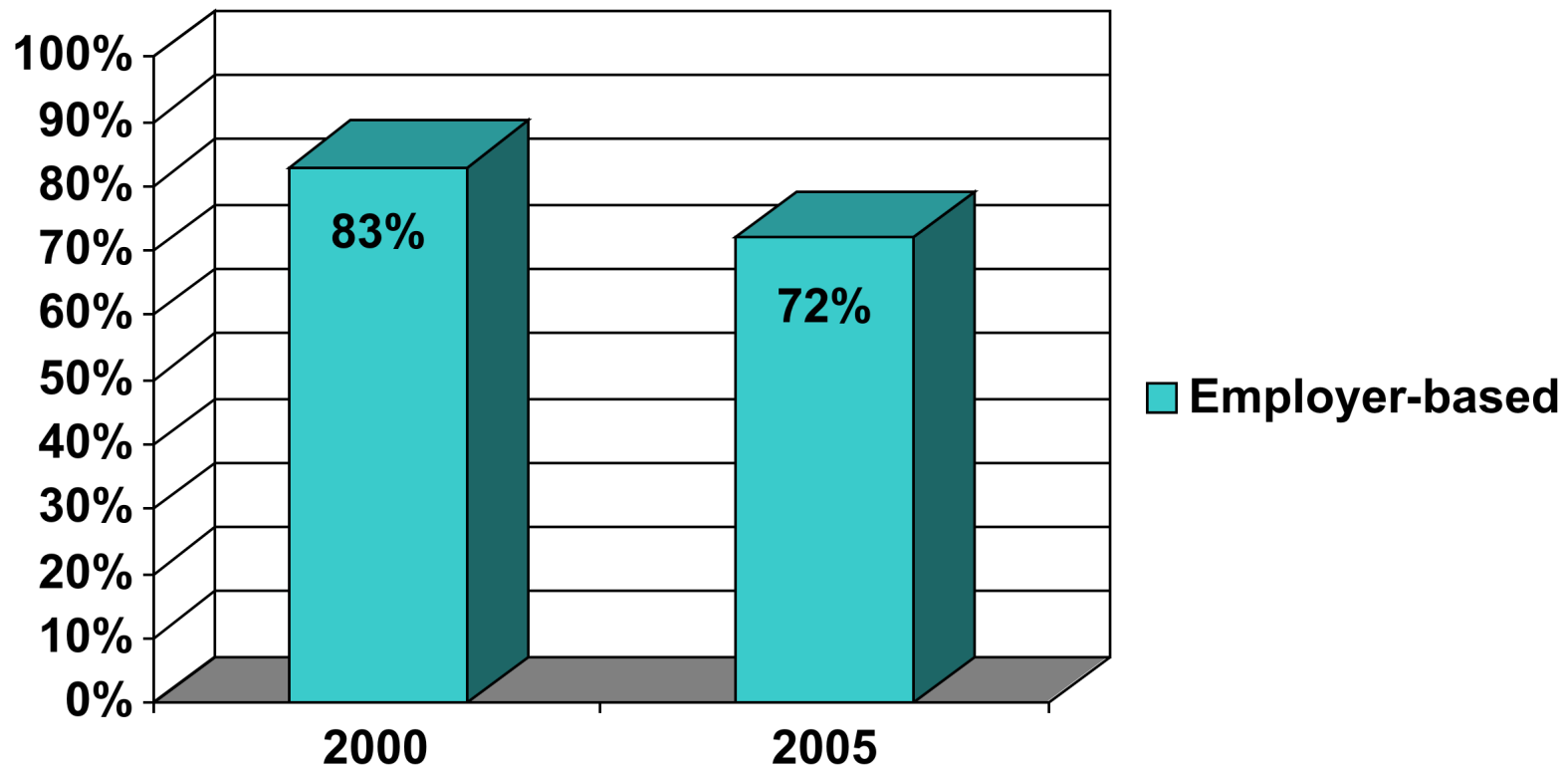
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Source: 2001 SPG report from CPS and IA consumer survey

# Uninsured adults

- 3/4 never turned down a job with coverage
- 1/4 declined coverage from work
- Among those declining coverage, 1/3 thought they would have to pay \$200 or more per month for insurance

# Employer-based coverage decline



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- 20% of children with pvt. Insurance in Medicaid at some point (3% in hawk-i)

# Employers



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# Employer coverage: Iowa

- In Iowa, 54% of employers offer health insurance
- Health insurance varies by number of employees
  - 97%- >50 employees
  - 85%-11-50 employees
  - 54%-4-10 employees
  - 30%-1-3 employees
- 50% of employers pay entire premium
- Uninsured employees more likely to be low wage

# Impact of coverage

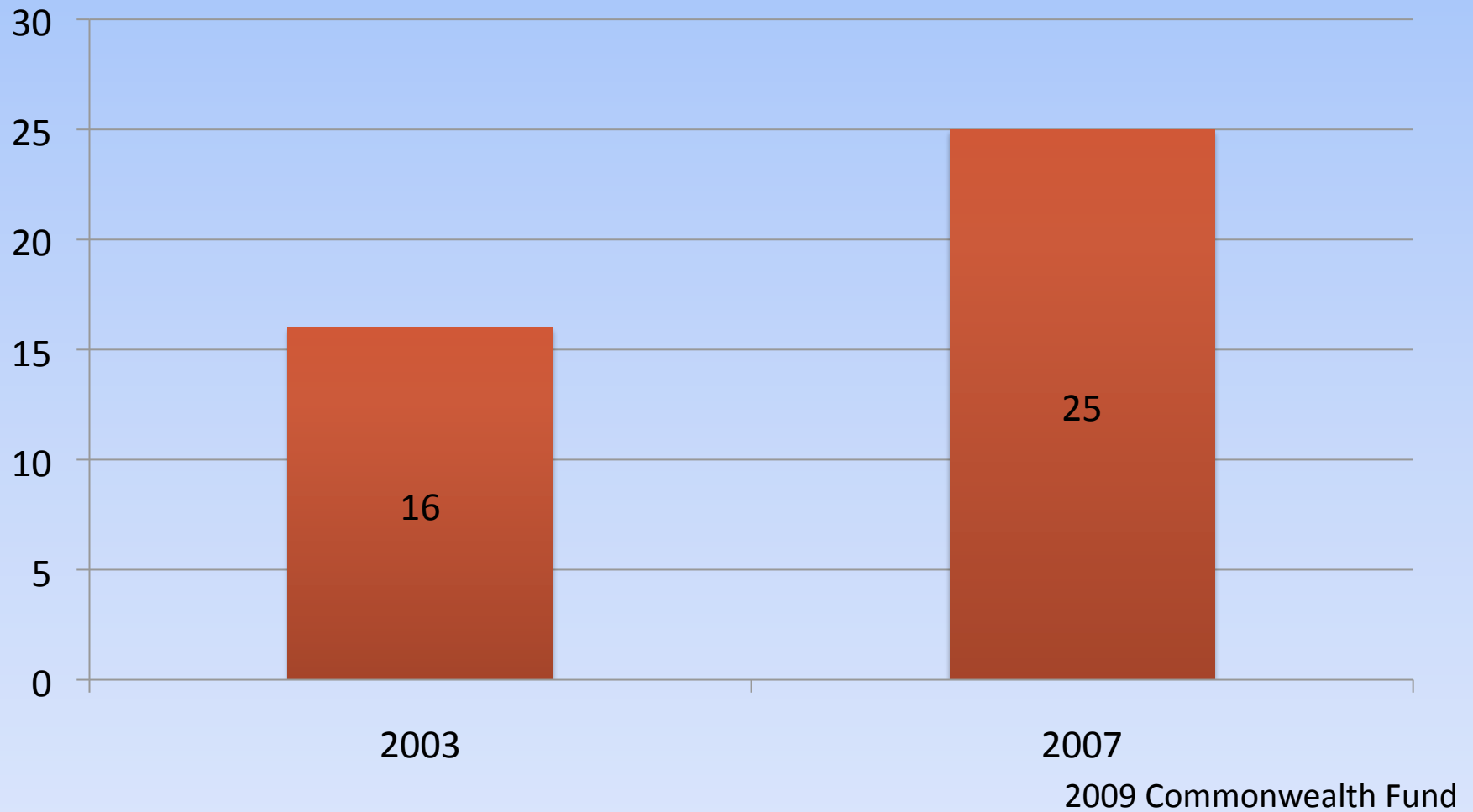


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# Impact of being uninsured

- Much less likely to have a regular source of care
- Had fewer doctor visits
- Much more likely to have an unmet need for medical care (17% vs 1%)
- Less able to get sick care
- More likely to have had an ER visit
- Less likely to have preventive visit in past year
- Most worried about paying for child's care

## Underinsured (in millions)



# Quality of care

System quality



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## WHO Rankings of Health Systems, 2000

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- 1 France
- 2 Italy
- 3 San Marino
- 4 Andorra
- 5 Malta
- 6 Singapore
- 7 Spain
- 8 Oman
- 9 Austria
- 10 Japan
- 11 Norway
- 12 Portugal
- 13 Monaco
- 14 Greece
- 15 Iceland
- 16 Luxembourg
- 17 Netherlands
- 18 UK
- 19 Ireland
- 20 Switzerland
- 21 Belgium
- 22 Columbia
- 23 Sweden
- 24 Cyprus
- 25 Germany
- 26 Saudi Arabia
- 27 UAE
- 28 Israel
- 29 Morocco
- 30 Canada
- 31 Finland
- 32 Australia
- 33 Chile
- 34 Denmark
- 35 Dominica
- 36 Costa Rica
- **37 USA**

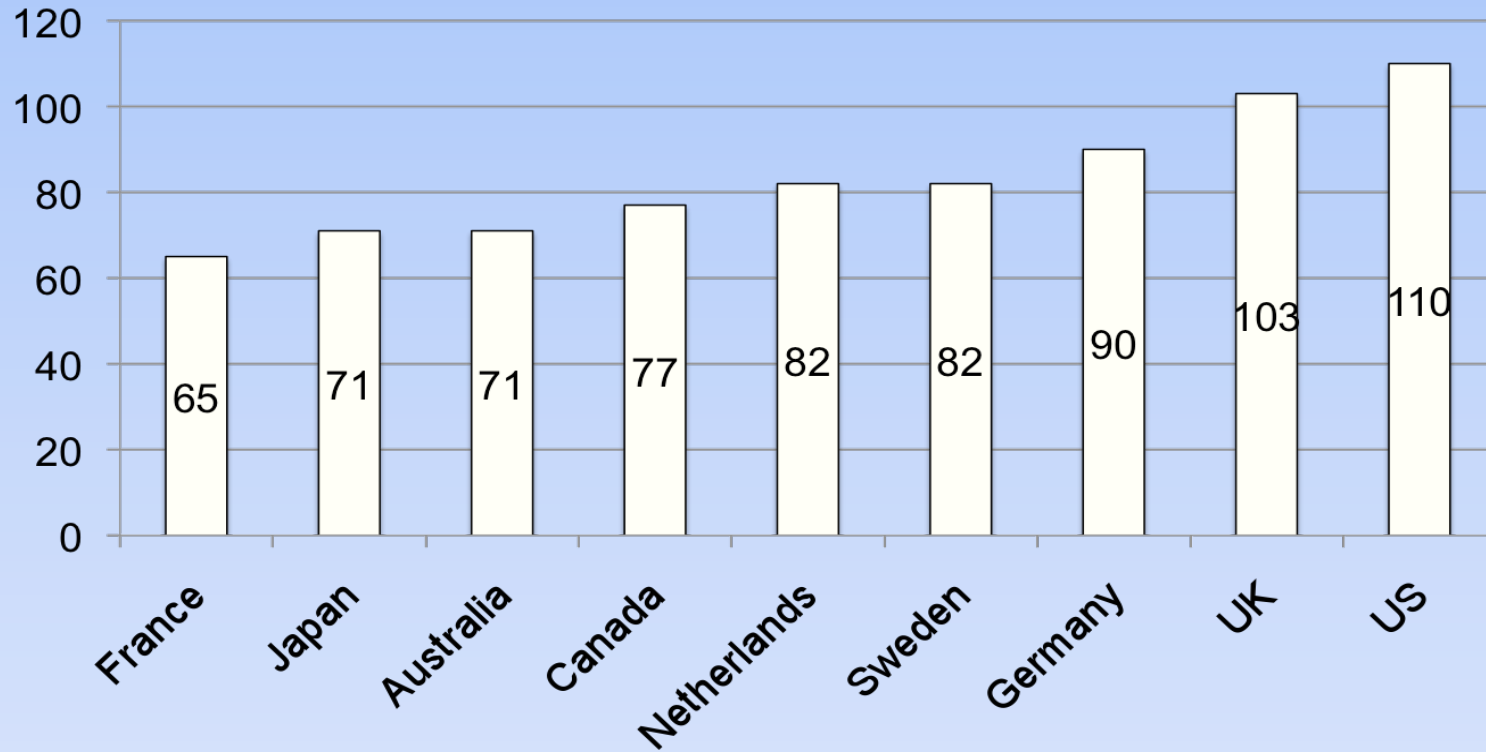
Source: WHO World Health Report

# Health Care Quality

| Country | Health spending | Female life expectancy | Male life expectancy | Infant mortality |
|---------|-----------------|------------------------|----------------------|------------------|
| US      | 1               | 7                      | 7                    | 7                |
| Germany | 2               | 5                      | 6                    | 3                |
| France  | 3               | 2                      | 5                    | 2                |
| Canada  | 4               | 3                      | 2                    | 4=               |
| Italy   | 5               | 4                      | 3                    | 6                |
| Japan   | 6               | 1                      | 1                    | 1                |
| UK      | 7               | 6                      | 4                    | 4=               |

Source: Kingsfund.org.uk, 2001

# Avoidable deaths



\*Deaths per 100,000 population Amenable to Health Care

Source: Nolte and McKee. Health Affairs 27(1):58-71, 2008

# Health care reform 2010 Style



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# The Patient Protection and Affordable Care Act (PPACA)

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## Health Care Reform Process 1993-94

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- Top down approach (White House developing proposal)
  - Expert panels working in secret
  - Tried to avoid special interest influence
- Many competing proposals working way through Congress
  - No buy-in from Congress and public
- Change more due to expected legislation than the legislation itself

# Health Care Reform Process 2009

Bottom up approach

- 3 House Committees produced one bill HF 3200

Now working on differences

- 2 Senate Committees with separate bills

Health, Education, Labor and Pensions (HELP)  
(Sen. Harkin now chair)

Budget Committee-Senator Grassley ranking  
minority member



# Near term policies

Fall 2010



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## Near term policies (fall 2010)

- Coverage of children up at age 26 on parent's policies
- Development of state/federal high risk pools
- Elimination of pre-existing conditions for children
- Requires insurance companies to pay out at least 80% of premiums for services

## Near term policies (fall 2010)

- Insurance companies banned from rescinding coverage because of illness and imposing yearly and lifetime caps on coverage.
- Small-business tax credits: Small businesses (fewer than 25 employees and average wages under \$50,000) that offer health care benefits eligible for tax credits of up to 35% of premiums for 2 years

## Near term policies (fall 2010)

- Preventive care: All new group and individual health plans will be required to provide free preventive care for proven preventive services.

## Near term policies (fall 2010)

- Establish process for reviewing health plan premium increases and justify increases.
- Require states to report on trends in premium increases and recommend if plans should be excluded from Exchange based on unjustified premium increases.

# Longer term policies

2014-19



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## Longer term policies (2014)

- Individual mandate begins.
- Large employer mandate begins (over 50 employees only)
- Medicaid expansion begins.
- Health insurance Exchanges begin to operate.

Individual

Small businesses



# Exchanges generally

- Health insurance marketplace (bazaar)
- Offer regulated products that meet standards
- Require two multi-state plans in each Exchange (federal employee plans)
- At least one plan must be offered by a non-profit entity

## Coverage for children

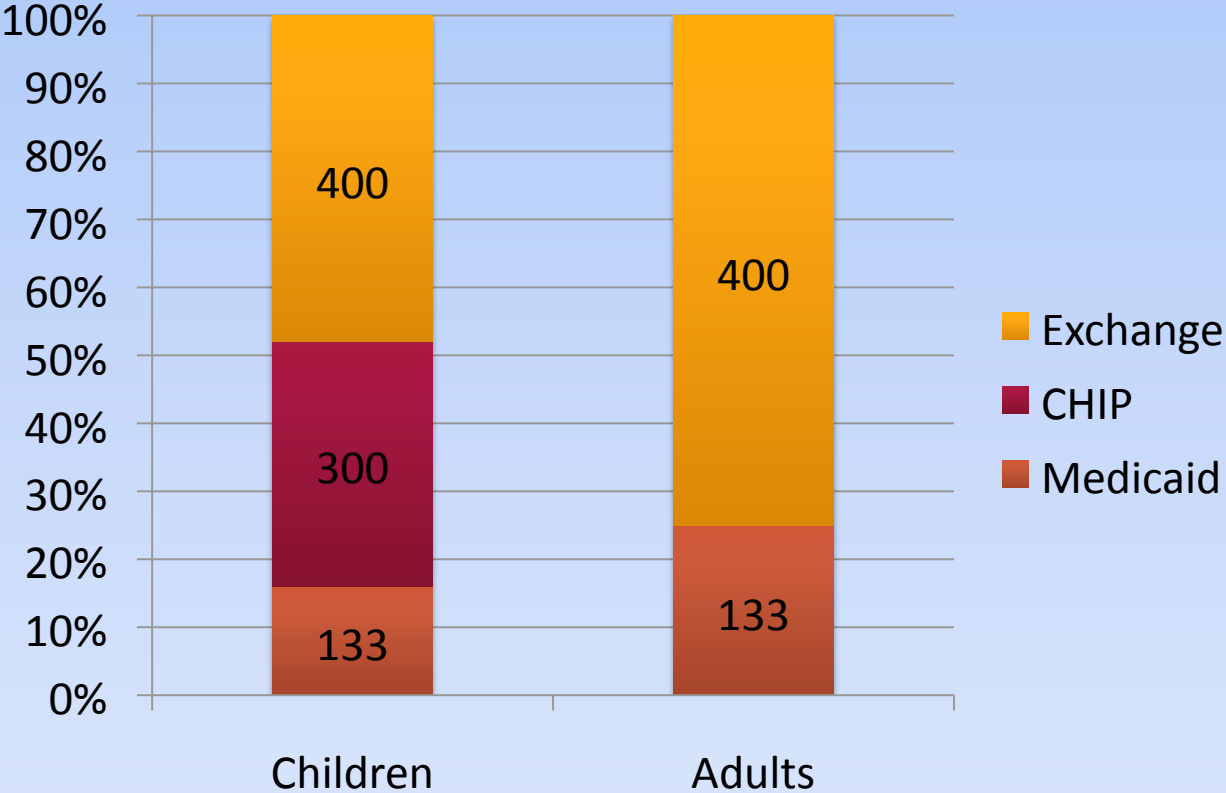
- Medicaid: up to 133% of FPL  
No change for Iowa
- CHIP: up to state approved level  
300% FPL in Iowa-no change
- Exchange: 300% of FPL and up

# Coverage for Adults

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- **Medicaid: up to 133% of FPL**  
Gets rid of categorical eligibility  
Eliminates IowaCare program (probably)
- **Exchange: 133% of FPL and up**

# Income eligibility for subsidy (%FPL)



# Health Insurance Exchange

- American Health Benefit Exchanges

## **Individuals**

100-200% FPL: \$1,983/individual and \$3,967/family;

200-300% FPL: \$2,975/individual and \$5,950/family;

300-400% FPL: \$3,987/individual and \$7,973/family

# Health Insurance Exchange

- Small Business Health Options Program (SHOP) Exchanges  
Up to 100 employees

# Impact on Seniors



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# Impact on Seniors

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- Medicare "Doughnut hole" rebates: \$250 rebates to those who hit Part D coverage gap (Fall 2010).
- Early retirees: Temporary reinsurance program to help offset costs of expensive premiums for employers providing retiree health benefits (Fall 2010).
- New office in CMS to coordinate care for Medicare/Medicaid eligible's (Fall 2010)

# Impact on Seniors

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- Ban new MD owned hospitals in Medicare (Fall 2010)
- Medicare will provide free preventive care for proven services (2011).
- 10% to primary care MDs and surgeons in HPSAs (2011)
- Restructure payments to Medicare Advantage Plans (2011)

# Impact on Seniors

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- Pay qualifying hospitals in lowest Medicare cost areas (2011)
- Freeze income thresholds for Medicare Part B premiums through 2019 at 2010 levels (2011)
- Reduce Part D subsidies for those with incomes above \$85,000 ind/\$170,000 couple (2011)

# Impact on Seniors

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- Begin phasing in subsidies for Part D doughnut hole (to 25% in 2020) (2013)
- Reduce out-of-pocket amount that qualifies for Part D catastrophic coverage (2013)

# Devil is in the details

- Implementation is critical  
State and Federal level
- Cost containment critical  
Care and premiums in the exchange