Health Care Reform: What Does It Mean for California, and the Nation?

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October 6, 2010
## Where Do Most Americans Get Health Insurance Coverage?

*From Their Employer!*

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Number (millions)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>194.5</td>
<td>63.9%</td>
</tr>
<tr>
<td>Employment Based</td>
<td>169.7</td>
<td>55.8%</td>
</tr>
<tr>
<td>Individual</td>
<td>27.2</td>
<td>8.9%</td>
</tr>
<tr>
<td>Government</td>
<td>93.2</td>
<td>30.6%</td>
</tr>
<tr>
<td>Medicare</td>
<td>43.4</td>
<td>14.3%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>47.8</td>
<td>15.7%</td>
</tr>
<tr>
<td>Military</td>
<td>12.4</td>
<td>4.1%</td>
</tr>
<tr>
<td>Uninsured*</td>
<td>50.7</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

* Including an estimated 1.5 million veterans

Note: Percentages exceed 100% because type of coverage is not mutually exclusive; individuals can have more than one category of coverage.

Source: U.S. Census Bureau Analysis of March 2010 Current Population Survey
The Growth of Private Insurance
1940-1960

Note: U.S. Population = 180 million in 1960 => 25% uninsured.
Employers Who Offer Health Insurance
A Tale of Two Cities

*Tests found no statistical differences from estimate for the previous year shown (p<.05).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

The Probability of Being Uninsured Is Substantial Below 400% FPL
Among the Non-Elderly Ages 0-64

- Below 100% FPL: 45% uninsured, 29% Medicaid/Other Public, 20% Employer/Other Private
- 100-199% FPL: 29% uninsured, 29% Medicaid/Other Public, 42% Employer/Other Private
- 200-299% FPL: 18% uninsured, 11% Medicaid/Other Public, 71% Employer/Other Private
- 300-399% FPL: 10% uninsured, 83% Medicaid/Other Public, 7% Employer/Other Private
- 400%+ FPL: 5% uninsured, 92% Medicaid/Other Public, 4% Employer/Other Private

NOTE: The federal poverty level (FPL) was $22,025 for a family of four in 2008. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.
Despite Claims to the Contrary, the Uninsured Are Not Mostly “Young Invincibles”

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Private</th>
<th>Medicaid/Public</th>
<th>Uninsured</th>
<th>Number of Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>55 - 64</td>
<td>72%</td>
<td>16%</td>
<td>13%</td>
<td>4.5 M</td>
</tr>
<tr>
<td>45 - 54</td>
<td>73%</td>
<td>11%</td>
<td>16%</td>
<td>7.1 M</td>
</tr>
<tr>
<td>35 - 44</td>
<td>71%</td>
<td>10%</td>
<td>20%</td>
<td>8.2 M</td>
</tr>
<tr>
<td>25 - 34</td>
<td>62%</td>
<td>11%</td>
<td>27%</td>
<td>10.8 M</td>
</tr>
<tr>
<td>19 - 24</td>
<td>55%</td>
<td>14%</td>
<td>31%</td>
<td>7.5 M</td>
</tr>
<tr>
<td>Under 19</td>
<td>58%</td>
<td>31%</td>
<td>10%</td>
<td>7.9 M</td>
</tr>
</tbody>
</table>

NOTES: Data may not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 ASEC Supplement to the CPS.
5% of the Population Accounts for 50% of Spending
20% Account for 80%

Percent of Population, Ranked by Health Care Spending

Note: Population is the civilian noninstitutionalized population, including those with no spending. Health care spending is total payments from all sources, excluding health insurance premiums.

Source: Kaiser Family Foundation calculations using data from Medical Expenditure Panel Survey (MEPS), 2005.
Average Payments to Medicare Advantage Plans Relative to Traditional Fee-for-Service Medicare, 2009

Traditional Fee-for-Service Medicare = 100%

- All Medicare Advantage Plans: 114%
- Local HMOs: 113%
- Local PPOs: 118%
- Regional PPOs: 112%
- Private Fee-For-Service Plans: 118%
- Special Needs Plans: 116%

Standard Medicare Prescription Drug Benefit, 2010

- **$421 Average Annual Premium in 2009**
- **$310 Deductible**
- **$2,830 in Total Drug Costs ($940 out of pocket)**
- **$3,610 Coverage Gap ("Doughnut Hole")**
- **$6,440 in Total Drug Costs ($4,550 out of pocket)**

**Beneficiary Out-of-Pocket Spending**

Major Elements of P.L. 111-148
The Patient Protection and Affordable Care Act of 2010

For those who are uninsured (in 2014):

- **Subsidies** => To make insurance more affordable to low- and middle-income individuals and families
- **Mandates** => To prevent cost-shifting and free riders from opting out of insurance until they need it
- **Insurance Exchanges** => To prevent insurers from setting premiums based on health status and encourage competition based on standard insurance policies

For everyone else:

- Provides additional protections to those with private insurance (in 2010 and 2011)
- Eliminates pre-existing condition exclusions (2014)
- Protects anyone who loses their employment-based insurance (2014)
Regulation of Current Private Insurance Markets
Starting 9/23/2010

Requires all private plans and policies to:

- Eliminate policy cancellations (i.e., rescissions)
- Eliminate lifetime dollar limits on benefits
- Extend coverage for children up to age 26
  - Children no longer have to be financially dependent
  - Excludes only those adult children: (a) who are eligible for their own employment-based insurance, and (b) whose parents have grandfathered plans in the group market (until 1/1/14)

Requires all private plans and policies, except grandfathered plans in the individual market, to:

- Eliminate preexisting condition exclusions for children <19 and, later, for adults (1/1/14)
- Eliminate “restrictive” annual dollar limits on benefits
  - <$0.75 million (9/23/10)
  - <$1.25 million (9/23/11)
  - <$2.00 million (9/23/12)
  - No longer allowed (1/1/14)

Requires only new private plans and policies to:

- Provide coverage for appropriate preventive services graded A or B by the USPSTF without applying copayments or deductibles
- Implement an internal appeals process and comply with an external review process that meets state or federal standards
- Allow pediatricians and OB/GYNs to be designated as primary care providers
- Allow use of ER services without preauthorization
Requires all private plans and policies to:

- Provide rebates to employees for policies with “excessive” administrative costs (1/1/11)
  - 20+% (firms with 2-100 employees)
  - 15+% (firms with 101+ employees)

- Eliminate premiums based on gender (1/1/14)

- Eliminate waiting periods for coverage >90 days (1/1/14)

- Limit deductibles for firms in the small group market (i.e., 2-100 employees) (1/1/14)
Individual Mandates, Penalties, and Subsidies
Starting 2014

- Imposes penalties for being uninsured of $695 per adult, up to a maximum of $2,085 per family or 2.5% of household income, whichever is greater
  - IRS is prohibited from prosecuting those who fail to pay this penalty (phased-in from 2014-2016)
  - Provides exemptions for financial hardship, religious objections, American Indian ethnicity, those uninsured <3 months, income below tax filing threshold, cost of least expensive plan is >8% income, the incarcerated, and the undocumented
- Provides subsidies (tax credits) for those from 133-399% FPL based on cost of Silver Plan:
  - Family premium limits ranging from 3.0% to 9.5% of income
  - Limits on annual out-of-pocket expenses also tied to income
  - Expands Medicaid coverage nationally to cover everyone with incomes <133% of FPL

Note: FPL = $22,050 for a family of 4 in 2010.
Employer Mandates, Penalties, and Subsidies
Starting in 2014

- Imposes a fee on employers with 50+ employees who do not offer insurance and have at least 1 FTE who receives a premium subsidy
  - $2,000 per FTE, excluding the first 30 employees

- Imposes a fee on firms that offer insurance but have at least 1 FTE who receives premium subsidies
  - Lesser of $3,000 per FTE receiving a subsidy, or $2,000 per FTE, excluding the first 30 employees

- Firms with <50 FTEs are exempt from mandate

- Starting in the 2010 tax year, tax credits are available for small employers with <25 FTEs and average wages <=$50,000
  - From 2010-2013, tax credit will be up to 35% of the employer’s contribution
  - Maximum credit is available to firms with no more than 10 FTEs and average wages <=$25,000
  - Starting in 2014, tax credit up to 50% for insurance purchased through the Exchange, but credit only available for two years

Note: FTE = worker averaging at least 30 hours per week
Creation of New Private Insurance Markets
Starting 2014

- Establishes State-based Insurance Exchanges:
  - Individual (i.e., non-group) market Exchange, for individuals who are uninsured and qualify for premium subsidies
  - Small group (i.e., <=100 employees) market Exchange
    - Open to large employers in 2017
  - Allows co-ops and "public" option (i.e., multi-state non-profit plans) to compete with private insurers

- Requires all new policies to include essential health benefits, both inside and outside the Exchanges
  - Grandfathered policies with non-standard benefits can still be offered outside the Exchanges

- Requires insurers to set premiums for all new policies using modified community rating based only on:
  - Age (premiums can vary by no more than 3 to 1)
  - Tobacco use (premiums can vary by no more than 1.5 to 1)
  - Family size
  - Geography
  - Health status cannot be used in setting premiums, except in grandfathered plans

- Retains small group and individual insurance markets, but insurers must:
  - Charge the same premium for policies with an essential benefits package inside and outside of the Exchanges
Creation of a Qualified Health Policy
Starting in 2014

- Establishes a qualified health policy with an essential benefit package that must cover at least 60% of the costs of these benefits.

- Establishes 4 tiers of the qualified health policy where the premium covers different dollar amounts of the essential benefit package:
  - Bronze => 60% premium / 40% out-of-pocket
  - Silver => 70% / 30%
  - Gold => 80% / 20%
  - Platinum => 90% / 10%
  - Catastrophic => only available for those up to age 30

- All qualified policies must limit annual out-of-pocket spending to:
  - $5,950 for individuals, $11,900 for families
  - Lower limits for those below 400% FPL who receive subsidies

- All qualified policies must:
  - Guarantee issue and renewal
  - Eliminate lifetime and annual dollar limits on benefits
  - Grandfathered plans are exempt from all these requirements, except:
    - lifetime limits
    - annual limits in the individual market
Impacts on Medicare

- Eliminates “doughnut” hole in Part D drug coverage
  - $250 rebate in 2010
  - 50% discount on brand-name drugs in 2011 from pharmaceutical manufacturers
  - Phases-in reduction in coinsurance rate from 100% to 25% by 2020

- Eliminates copayments for covered preventive services in 2011

- Phases-in reductions in payments to Medicare Advantage plans starting in 2011
  - <$30 per month => 3-year phase-in
  - $30-$49 per month => 4-year phase-in
  - $50+ per month => 6-year phase-in
Impacts on Medicare

- Reduces the growth rate in payments to providers (except physicians)
  - Introduces adjustment for productivity increases
  - Reduces subsidies to hospitals that covered the costs of uncompensated care

- Freezes income thresholds for paying higher Part B premiums at $85,000 per individual and $170,000 per couple through 2019
  - Establishes same income thresholds under Part D starting in 2011

- Increases Medicare Part A payroll tax for high-income earners from 1.45% to 2.35% and imposes a new 3.8% tax on unearned income beginning in 2013
  - $200,000 per individual and $250,000 per couple
Financing: 2010-2019

Total cost = $1.044 trillion, minus offsets:

- Reductions in the growth of Medicare and Medicaid payments and other program efficiencies = $455 billion
- Excise tax on “high-cost” employment-based insurance = $32 billion
- Penalty payments by individuals and firms = $69 billion
- New excise taxes = $107 billion
  - Pharmaceutical companies
  - Medical device manufacturers
  - Health insurers
  - Tanning salons
- Increase in Medicare payroll taxes for high-income earners = $210 billion

Other revenue and offsets = $189 billion

Total new taxes plus reduced government spending = $1.062 trillion

*Net impact = $18 billion deficit reduction*
For more information on the legislation, visit the following web sites:

Kaiser Family Foundation:  
http://healthreform.kff.org

The Commonwealth Fund:  
http://www.commonwealthfund.org/

Thank you!