THE COMMONWEALTH FUND

The Commonwealth Fund Blog

June 28, 2012

Nation to Move Forward on Ensuring Affordable Access to High-Quality Care for All

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Today, the Supreme Court upheld the constitutionality of the Affordable Care Act. This decision allows state and federal policymakers across the country to move forward in their work implementing the provisions of the law. Over the next decade, 32 million previously uninsured people could gain affordable and comprehensive health insurance coverage as a result of the law.

The Affordable Care Act has already begun to transform both insurance markets and the nation's health care delivery system. An estimated 6.6 million young adults enrolled in a parent's health plan in 2011 as a result of the law's requirement that employers and insurers that offer dependent coverage include adult children to age 26. Seven states and the District of Columbia have used new federal matching funds to expand eligibility for adults through their Medicaid programs, covering 600,000 people. Almost all states have taken legislative or regulatory steps to implement the law's early insurance market reforms, including banning insurance carriers from imposing limits on what they will pay over a lifetime and coverage of preventive care services without cost-sharing. This year, insurance carriers either lowered their premiums or will pay consumers and small businesses rebates amounting to more than $1 billion under the law's requirement that they spend at least 80 to 85 percent of their premium revenues on medical costs, as opposed to administration and profits. Nearly 62,000 uninsured people with preexisting health conditions have gained coverage through state-based preexisting condition insurance plans.

Through new grants and incentives to providers and communities, the law is also accelerating widespread change in the way in which health care is delivered in the United States—encouraging hospitals, physicians, and insurers to coordinate care around patients' needs, eliminate waste, and reduce medical errors. The recent slowdown in U.S. health care spending is at least partly reflective of these fundamental changes taking place.

Moving Forward—What States Can Do Now

Today's decision allows states, in partnership with the federal government, to use the considerable amount of federal funding available to implement the major provisions of the health care reform law that will go into effect in 2014. By taking advantage of these new resources, states will bring near-universal, affordable, and comprehensive coverage to their residents; lower uncompensated care costs to hospital and state budgets; reduce soaring rates of medical debt among their residents; decrease the rate of growth in health care costs and premiums; and help create a delivery system that is patient-centered, safe, and efficient.

Implementing the Medicaid Expansion

The law creates the largest expansion in Medicaid since the program's inception in 1965 by covering all legal residents with incomes up to 133 percent of poverty, or $14,856 for an individual and $30,657 for a family of four, beginning in 2014. The federal government will provide the majority of financing to states for the expansion, covering 100 percent of the costs in most states through 2016 before gradually reducing its contribution to 90 percent for all states by 2020. This translates into an infusion of federal dollars into states on the order of $668 billion over 2014–20, and will substantially reduce each state's number of uninsured residents and total uncompensated health care costs. The Supreme Court today ruled that states may expand their Medicaid programs under the conditions of the law and receive federal financing for them. But states that choose not to participate in the expansion may still maintain existing federal Medicaid funding. If all states choose to participate in the expansion, the Congressional Budget Office estimates that 17 million people could gain new coverage under the program by 2020.

Some states have already moved forward on their Medicaid expansions. In 2010, the law allowed states to use current Medicaid federal matching funds to cover adults with incomes up to 133 percent of poverty. States also had the option of applying for a Medicaid waiver, which can provide funds to cover those with incomes over 133 percent of poverty. The Kaiser Family Foundation reports that as of January 2012, seven states (California, Connecticut, Colorado, Minnesota, Missouri, New Jersey, and Washington) and the District of Columbia received approval to expand Medicaid to low-income adults either through the new federal matching option under the Affordable Care Act and/or through the waiver, covering nearly 600,000 adults. Nearly all the states used the matching funds to help cover the costs of a state or county-funded program.

Implementing the State Insurance Exchanges

The state insurance exchanges are the centerpiece of the Affordable Care Act's coverage expansions, creating new marketplaces that will serve as the central portal through which people will go for coverage if they do not have an affordable employer-based health plan. States can run the new exchanges themselves, or work in partnership with the federal government to operate them. As of June, 13 states and the District of Columbia have given themselves the legal authority to operate their own exchanges. The U.S Department of Health and Human Services (HHS) has awarded a total of $845 million in grants to 34 states to establish their exchanges. By November 16 of this year, states must submit "blueprint" applications to HHS indicating that they will operate their own exchanges, or that they will assume some responsibilities of exchange operation under a federally operated exchange. Open enrollment in the exchanges begins in October 2013.

The federal government will provide premium and cost-sharing tax credits for health plans sold through the state insurance exchanges to people in families earning up to 400 percent of poverty ($44,680 for an individual and $92,200 for a family of four) who lack an offer of affordable coverage. The Congressional Budget Office (CBO) estimates that at least 23 million people will be insured through the exchanges by 2020, the majority of whom will receive federal tax credits to offset the cost of their insurance and out-of-pocket costs. Federal spending on tax credits and other exchange-related activities amount to an estimated $553 billion flowing through the state exchanges over 2014–20.

Selecting the Essential Health Benefits Package and Implementing Insurance Market Reforms

All states, even those that elect a federal exchange, are to select a representative health plan in the next year that will form the basis of the essential health benefits package that will be sold in both exchanges and the individual and small-group markets. This requirement ensures that people in the exchanges have health plans that are comparable to those in employer-based plans, ensuring access to needed care and protection from medical debt. States can choose a plan from four different options: any of the three largest small-group plans in the state by enrollment, any of the three largest state employee health plans, any of the three largest Federal Employees Health Benefits Program (FEHBP) plan options, or the largest commercial non-Medicaid health maintenance organization (HMO) plan operating in the state.

In preparation for the 2014 coverage expansions, all states must also ensure that the new federal insurance market reforms that go into effect in 2014, including those that ban insurers from denying people health insurance or charging higher premiums on the basis of health, are part of state law or their regulatory apparatus so that all their residents will benefit from these new protections.

The Requirement to Have Health Insurance

In today's decision, the Supreme Court upheld the constitutionality of the Affordable Care Act's requirement to have health insurance. But there remains widespread confusion about the provision and its purpose. The requirement is a central provision in the law for decreasing the risk and effects of "adverse selection" (when people wait to enroll in a health plan until they get sick) in the exchanges. Beginning in 2014, everyone is required to indicate on their tax forms whether they have health insurance that meets minimal essential benefit standards, with some people having to pay a penalty if they do not have insurance. The penalty is equal to the greater of $95 or 1 percent of taxable income in 2014, $325 or 2 percent of taxable income in 2015, and $695 or 2.5 percent of taxable income in 2016 up to a maximum of $2,085 per family. The dollar amount of the penalty is capped at $2,085 per family, and no one would pay more in penalties than the national average premium for the bronze plan to be sold through the exchanges.

But under the law, no one will be prosecuted because they do not have health insurance. Moreover, there are numerous exemptions to the penalty for not having health insurance, including: individuals who could not find a health plan that costs less than 8 percent of their income, net of subsidies and employer contributions; people with incomes below the tax-filing threshold ($9,750 for an individual, $19,500 for a married couple, $27,100 for a married couple with two children); people who have been without insurance for less than three months; and certain other circumstances.

In fact, the exemptions to the penalties are so extensive that the Urban Institute estimates that just 7 percent of the nonelderly U.S. population would have been required to newly purchase coverage or be subject to a penalty if the mandate had been implemented in 2011.

Despite the current focus on the individual requirement to have health insurance, the primary purpose of the Affordable Care Act's coverage provisions are not to penalize people for being uninsured, but to make insurance affordable and accessible for everyone, for the first time in the nation's history. Beginning in 2014, 90 percent of the 49 million currently uninsured people under the age of 65 either could be eligible for new coverage under Medicaid, which has no premium contributions, or subsidized private health plans in which premium costs are capped as a share of people's income from 2 percent to 9.5 percent. In addition, the law provides both cost-sharing subsidies and limits on out-of-pocket spending, also on a sliding scale based on income. For the first time, people who are buying coverage on their own will not pay more based on their health status and will have access to health plans that cover essential health services, similar to those covered in employer plans.

Improving Care and Reducing Health Care Costs

The Affordable Care Act includes an extensive set of new demonstration programs and incentives aimed at improving the quality and cost of health care. Such changes include payment innovations, among them, higher reimbursement for preventive care services and patient-centered primary care; bundled payment for hospital, physician, and other services provided for a single episode of care; shared savings for accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers. In combination with the insurance market reforms and new revenues, these provisions are expected to more than offset the cost of the coverage expansions. CBO estimates the Affordable Care Act will reduce the federal deficit by $124 billion between 2012 and 2021. David Cutler, Karen Davis, and Kristof Stremikis estimate even greater savings from the law's delivery system reforms than CBO: $406 billion in savings through delivery system reforms in the law by 2019, and consequently a much greater net decrease in the deficit of $400 billion by 2019. The authors estimate that the combination of insurance and delivery system reforms in the law could lower family premiums by $2,000 by 2019.

Indeed, the current wave of delivery system innovation taking place in states across the country even as the law is being implemented suggests that these larger savings might ultimately be realized. Several patient-centered medical home interventions, both in the Medicaid program and initiated by private payers, have realized significant reductions in hospitalizations and emergency department use. New provider payment arrangements and incentives have slowed spending growth in parts of the country, and a nationwide program to reduce hospital readmissions has already resulted in statistically significant reductions in 30-day hospital readmission rates in Massachusetts and Michigan.

Looking Ahead

A recent Commonwealth Fund survey found that one-quarter of adults ages 19 to 64 experienced a gap in their health insurance in 2011, with a majority remaining uninsured for one year or more. Compared with adults who were insured, those who experienced gaps were less likely to have a regular doctor and less likely to be up-to-date with recommended preventive care tests, with rates declining as the length of the coverage gap increased. Early provisions of the Affordable Care Act are already helping bridge gaps in coverage among young adults and people with preexisting conditions. Beginning in 2014, new affordable insurance options through Medicaid and state insurance exchanges will enable Americans to remain insured even in the face of extended periods of unemployment.

Ultimately, the success of the law in providing near universal coverage that continues to be affordable in the years to come will depend on the way in which federal and state governments choose to implement key provisions, in particular the design and operation of the insurance exchanges, the participation of all states in the Medicaid expansion, and the willingness of health care providers to engage in payment and delivery system innovations. In the wake of the Supreme Court decision, it is critical that state and federal policymakers, regulators, and key stakeholders work in concert to realize the potential of this historic law.