



Who Is Helped by Health Reform?

By Karen Davis



This spring—98 years after Theodore Roosevelt first proposed comprehensive health care—the United States joined the world’s other major industrialized nations in providing all its citizens with access to essential health care.

[Commonwealth Fund analysis](#) shows that the Patient Protection

and Affordable Care Act will deliver on all three of the goals President Obama set forth when Congress began crafting reform legislation last year:

- expand access to affordable health insurance for those without coverage;
- increase the affordability of insurance for those who already have it; and
- slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.

Given the complexity of the law, questions linger about how it will affect people’s lives, specifically about what groups of Americans will be helped by health reform and how our experiences with the health care system will change. In this first part of a two-part blog post on the law’s impact, I will explore how different groups will benefit from the new coverage options, benefit standards, and insurance market rules. The upcoming post will look at the benefits for patients of the health system changes contained in the new law.

- 1. Uninsured individuals, whether low- or modest-wage workers or unemployed, will be able to get and afford the coverage and care they need.**

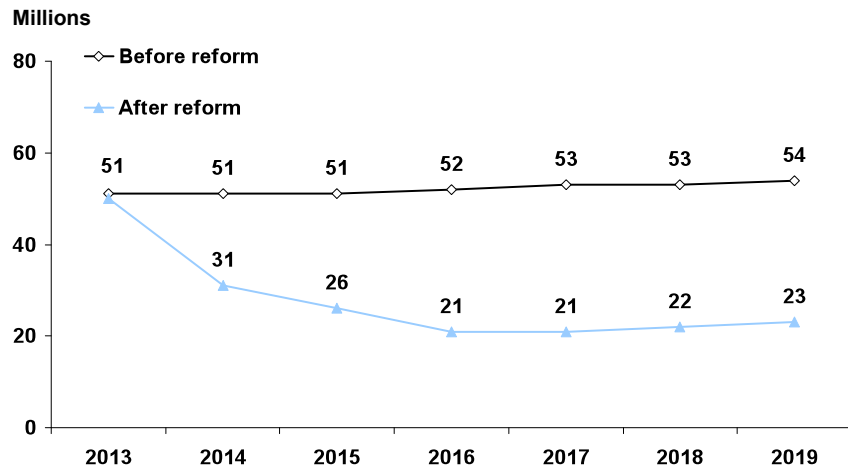
The [Congressional Budget Office](#) (CBO) estimates that by 2019 health reform will increase the proportion of the insured population from 83 percent to 94 percent. About half of the 32 million newly insured will be covered by Medicaid, and the other half will receive help in purchasing private coverage. Some will take up employer coverage for the first time. Those without employer coverage can receive federal assistance to purchase qualified health plans through the insurance exchanges; this applies to individuals and families earning between 133 percent and 400 percent of the federal poverty level (between \$29,327 and \$88,200 for a family of four). Within that income range, premium contributions will be limited to between 3.0 and 9.5 percent of a family’s income.

- 2. Young adults graduating from high school or college will no longer be uninsured and no longer dependent on emergency rooms for care.**

Nearly 30 percent of [young adults](#) are uninsured, often aging out of their parents’ plans and unable to find jobs that offer health insurance benefits. Fifty-three percent report going without needed care in the last year, and four of 10 report difficulty paying medical bills or accumulated medical debt. One-fourth of young adults use emergency rooms during the year, incurring bad debts that may affect their future credit as well as the financial stability of safety-net institutions serving those who cannot pay.

Effective September 2010, young adults will be permitted to stay on their parents’ insurance policies up to age 26, or until they find a job with health benefits. In 2014, about

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



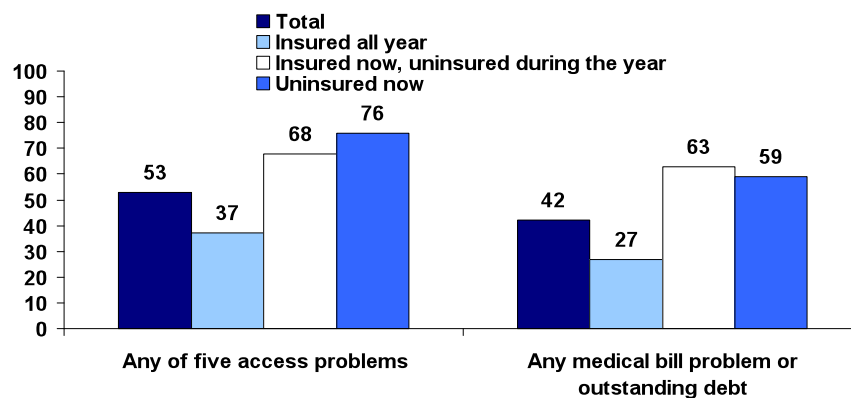
Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% of legal nonelderly residents are projected to have insurance under the new law.
Source: K. Davis, *A New Era in American Health Care: Realizing the Potential*, (New York: The Commonwealth Fund, June 2010).

7 million young adults with incomes below 133 percent of the poverty level (\$14,404 for a single adult) will become eligible for Medicaid; states have the option to cover low-income adults beginning in 2010 at the current federal matching rate. In addition, young adults will be able

to purchase coverage through health insurance exchanges in 2014; [85 percent](#) of those young adults (those with incomes below four times the poverty level of \$43,320 for a single adult) will be eligible to receive help paying premiums and medical bills.

Uninsured Young Adults Most Likely to Have Cost-Related Access Problems and Medical Bill or Debt Problems in the Past Year

Percent of adults ages 19–29 reporting cost-related access problems or medical bill or debt problems:



Notes: Access problems include not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care. Medical debt or bill problems include not being able to pay medical bills; being contacted by a collection agency; changing way of life to pay medical bills; and medical bills/debt being paid off over time.
Source: S. R. Collins and J. L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010*, (New York: The Commonwealth Fund, May 2010).

3. Workers will no longer lose coverage when changing jobs.

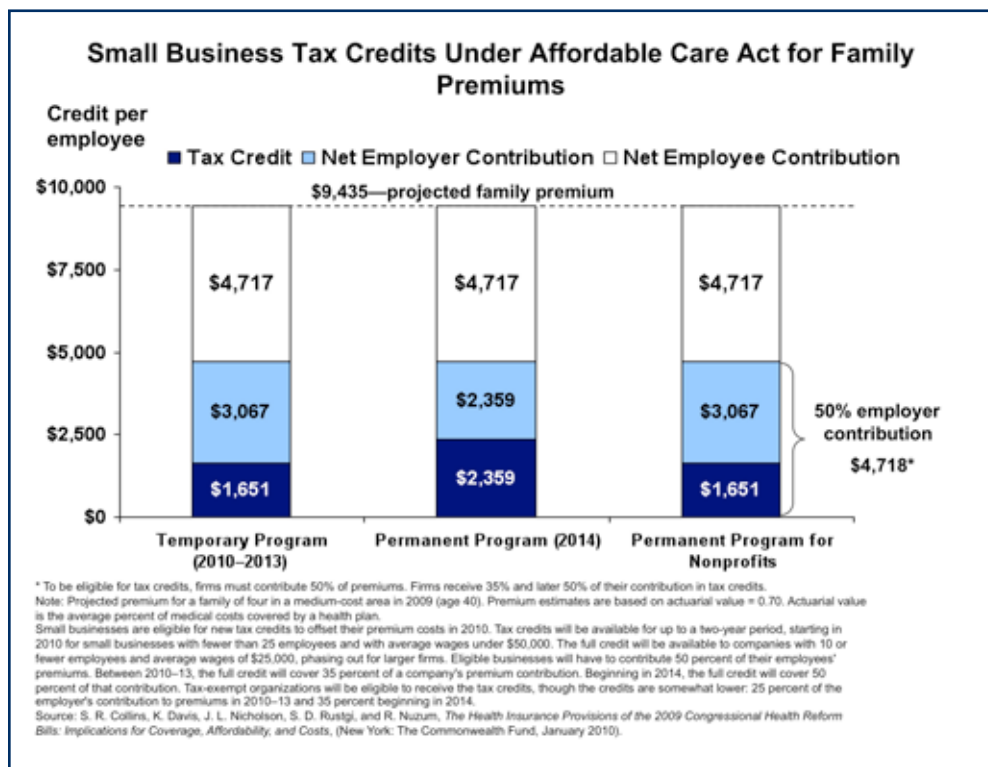
Thirty-two percent of adults report at least one change in their health plan in the past three years. These changes in coverage often result in spells without any insurance, loss of certain benefits, or the need to change doctors. Such changes can have serious consequences for continuity of care and proper management of chronic conditions.

The new health reform law will help workers at every income level keep their insurance coverage if they already have it, or purchase coverage if they don't. Beginning in 2014, workers in small businesses or those buying insurance in the individual market will be able to purchase coverage through insurance exchanges that more efficiently pool risk and reduce administrative costs. After 2017, states have the option of opening the exchange to businesses of any size.

4. Small business owners will be able to offer health coverage and afford premiums.

About 78 percent of firms with 10 to 24 employees and 49 percent of businesses with three to nine employees now offer coverage to their workers—even though insurance premiums for small businesses tend to be higher than premiums for larger businesses for health plans with similar benefits. These percentages may increase as workers seek to fulfill their obligation to carry health insurance. In Massachusetts, for example, the share of workers with employer coverage increased from 80 to 84 percent under health reform, as more employers offered coverage and some workers who had been eligible for coverage opted to take it up.

As an added incentive for employers to offer coverage, tax credits will be available to offset up to 35 percent of employers' premium contribution for two years for low-wage businesses with fewer than 25 employees. A temporary program is slated to begin in 2010; the permanent program, scheduled to start in 2014, will provide up to a 50 percent credit for two years.



In 2014, small employers can elect to purchase coverage for their employees through the exchanges, taking advantage of the reduced administrative costs and lower premiums they will bring.

5. Families will face fewer difficulties paying out-of-pocket expenses.

Shrinking coverage—the typical employer plan now covers 80 percent of average medical expenses—and increasing deductibles during the past decade have resulted in a sharp rise in the number of Americans who face substantial out-of-pocket costs, rendering them “underinsured.” One-fourth of insured Americans who have difficulty paying their medical bills report using all their savings or taking on credit card debt to pay those bills.

Beginning in 2014, insurance plans must meet essential benefit standards covering hospital care, physician services, prescription drugs, preventive services without cost-sharing, and pediatric dental and vision care, among other benefits. The benefit requirements do not apply to grandfathered plans or self-insured plans. Plans will be classified into different “tiers” to allow families to understand their out-of-pocket liability. Actuarial values—the proportion of costs actually covered—will range from 60 percent (bronze tier)

to 90 percent (platinum tier). The percentage of expenses covered will vary depending on family income, and out-of-pocket expenses will be limited for individuals and families of all income levels.

6. Low-income mothers will be able to afford prenatal care and have a healthy baby.

[Work by the Commonwealth Fund](#) shows that many women face problems securing affordable health coverage and care. Women are less likely to have employer-sponsored insurance available to them and often must seek coverage in the more expensive individual market. The practice of gender rating means that women pay substantially more than men for similar or worse insurance. Pregnant women without employer coverage face particular difficulty securing adequate individual coverage for prenatal care: a [recent study](#) showed that across the country, just 13 percent of individual insurance market plans available to a 30-year-old woman provided maternity coverage.

Beginning in 2014, insurers will be prohibited from charging higher premiums because of gender, health status, or family history. Pregnant women in the Medicaid program will see new coverage options for freestanding birth centers and have access to free smoking cessation programs. The

More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt

| Percent of adults reporting: | Total | Insured All Year | | Uninsured Anytime During Year | |
|--|-------|----------------------------|--------------|--|---------------|
| | | No underinsured indicators | Underinsured | Insured now, time uninsured in past year | Uninsured now |
| Unable to pay for basic necessities (food, heat, or rent) because of medical bills | 29% | 16% | 29% | 42% | 40% |
| Used up all of savings | 39 | 26 | 46 | 46 | 47 |
| Took out a mortgage against your home or took out a loan | 10 | 9 | 12 | 11 | 11 |
| Took on credit card debt | 30 | 28 | 33 | 34 | 26 |
| Insured at time care was provided | 61 | 80 | 82 | 46 | 24 |

Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, (New York: The Commonwealth Fund, August 2008).

Department of Health and Human Services, meanwhile, is authorized to make grants to states to promote improvements in maternal, prenatal, and infant health. And states are eligible to receive federal funds to provide home visitation services for maternal health and prenatal care.

7. Men and women will have access to preventive care and cancer screening for early detection.

Despite significant strides in improving the delivery of preventive services, many adults still fail to receive recommended preventive care and cancer screening. The Commonwealth Fund's [National Scorecard](#) on U.S. Health System Performance finds that only half of all adults, and less than one-third of uninsured adults, are up to date with recommended preventive care and screening services.

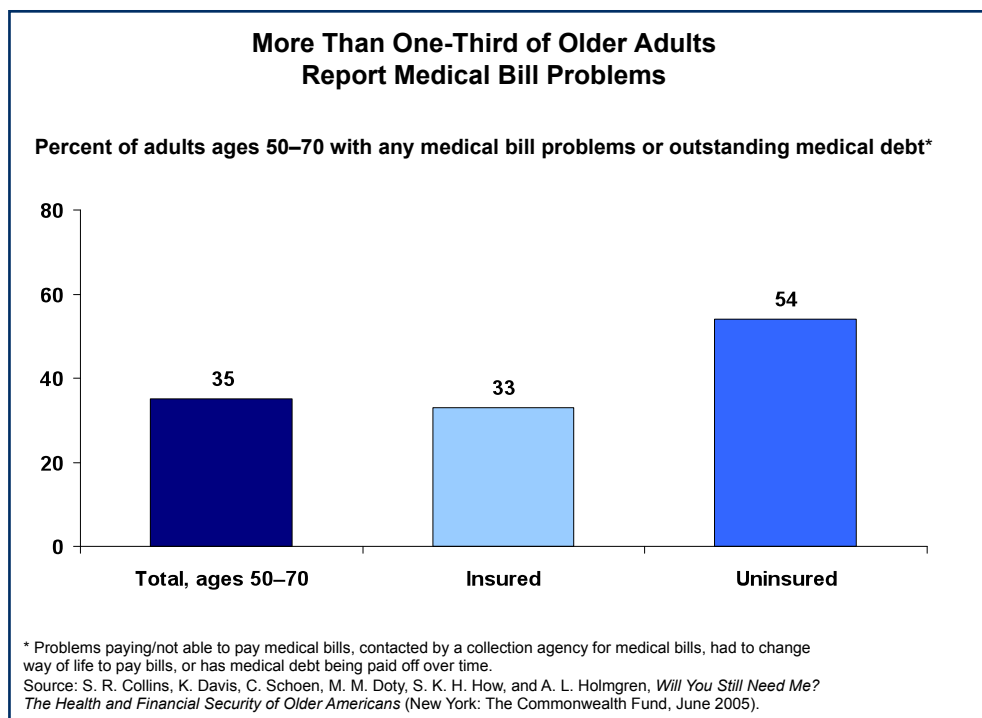
Beginning in 2010, all recommended preventive services will be covered without cost-sharing under new individual and group plans (for Medicare beneficiaries, this will begin in 2011). States that expand Medicaid coverage to include approved preventive services with no cost-sharing will receive increased federal funding for these services. This will remove financial barriers to care and save lives.

8. Older adults will no longer be denied coverage because of health problems and preexisting conditions.

Older adults seeking health insurance coverage typically face prohibitively high premiums, large deductibles, and troubling exclusions for health problems and preexisting conditions. A [Commonwealth Fund study](#) found that 24 percent of the near-elderly (ages 50 to 70) failed to get health care services because of the cost. More than one-third (35%) had a problem paying their medical bills in the last year or were paying off medical debt they had accrued over the last three years.

Beginning 90 days after enactment of the law, older adults with preexisting conditions who have been uninsured for at least six months will be eligible for subsidized insurance through a national or state high-risk pool. Older adults will pay no more than four times what younger adults pay for coverage.

In 2014, insurance companies will be required to cover all individuals regardless of health status and charge the same premium regardless of preexisting conditions. Premiums may vary based on age, but by no more than a three-to-one ratio. These provisions will greatly increase the affordability and availability of coverage for older adults with health problems.



9. Individuals with functional limitations will be able to afford help to continue living at home.

More than 10 million Americans are estimated to need long-term care assistance and support to perform daily activities, but long-term care is simply unaffordable for the majority of the population. While Medicare covers some short-term skilled nursing and home health care, Medicaid is the only program available to finance care for those with long-term disabilities and needs and without significant income or assets. Unfortunately, workers and retirees with functional limitations must “spend down” their savings—essentially impoverishing themselves—before becoming eligible for Medicaid assistance.

The health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports in 2012. Known as the CLASS program, it will provide a cash benefit to individuals with limitations, enabling them to purchase nonmedical services and supports necessary to remain at home. After a five-year vesting period, the program will begin to provide benefits to those who need assistance. The program is financed through voluntary payroll deductions—all working adults will be automatically enrolled in the program unless they opt out.

10. Medicare beneficiaries will receive free preventive care and no longer face the prescription drug “doughnut hole.”

Medicare prescription drug coverage currently includes a gap—known as a “doughnut hole”—where beneficiaries are required to pay 100 percent of their prescription drug costs between \$2,700 and \$6,154. Under health reform, Medicare beneficiaries entering the coverage gap will receive a \$250 rebate in 2010. In 2011, beneficiaries covered by private drug plans (other than those with high incomes) will receive a 50 percent discount on brand-name drugs. Beneficiaries will then receive additional discounts on brand-name and generic drugs, to close the doughnut hole by 2020. Rather than paying 100 percent of prescription costs in the gap range, beneficiaries will pay 25 percent.

In addition, beginning in 2011, Medicare beneficiaries are eligible for an annual wellness visit and all recommended preventive services, without any cost-sharing.

It’s clear that a majority of Americans stand to benefit from the Affordable Care Act. This law ushers in a new era in U.S. health care—one in which every American has access to affordable health insurance coverage and no one is turned away simply because they have a preexisting condition. The new insurance market protections are designed to work in concert with important payment and system reforms that will improve access and quality and reduce cost growth for everyone; I will address these reforms in my next blog post.

