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Realizing Health Reform's Potential: *Adults Ages 50–64 and the Affordable Care Act of 2010*

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Abstract: The Patient Protection and Affordable Care Act, which will provide health insurance to nearly all U.S. citizens and improve the quality of health insurance, will particularly benefit adults ages 50 to 64, a group suffering from extended unemployment and a loss of employer health benefits. Several early provisions that go into effect in 2010, including preexisting condition insurance plans, will provide transitional assistance for adults who have struggled to gain health insurance. The biggest improvements will come in 2014 through a significant expansion in eligibility for Medicaid and the creation of health insurance exchanges with subsidized private insurance for people with low and moderate incomes. Of the 8.6 million adults ages 50 to 64 who were uninsured in 2009, up to 6.8 million may gain subsidized insurance through Medicaid and the exchanges and 1.4 million with higher incomes will have access to comprehensive health plans with new consumer protections.

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OVERVIEW

The number of men and women between the ages of 50 and 64 who are uninsured climbed to 8.6 million in 2009, an increase of 1.1 million from 2008 (Exhibit 1).¹ About 4.2 million women and 4.3 million men were without health insurance. In addition, an estimated 9.7 million adults in this age group—sometimes known as “baby boomers”—have health insurance with such high out-of-pocket costs relative to income that they are effectively underinsured.² The Patient Protection and Affordable Care Act of 2010 will provide health insurance to all U.S. citizens starting in 2014 and significantly improve the quality of health insurance. In particular, of the 8.6 million 50-to-64-year-olds who were uninsured in 2009, up to 6.8 million would gain subsidized coverage once all the law's provisions go into effect in 2014—3.3 million in families earning less than 133 percent of the federal poverty level would gain coverage under Medicaid and 3.5 million earning less than 400 percent of poverty would gain subsidized private coverage through the insurance exchanges (Exhibit 2). In addition, about 1.4 million older currently uninsured adults with incomes of 400 percent of poverty or higher would have access to health insurance plans through the exchanges. Plans offered both inside and outside the exchanges will provide comprehensive benefits

and insurers will be prohibited from excluding anyone from coverage or charging higher premiums because of preexisting health conditions. About 377,000 currently uninsured individuals are undocumented immigrants and not eligible for Medicaid or coverage through the insurance exchanges.³ The estimated 9.7 million underinsured older adults would realize more comprehensive benefit packages and greater cost protection.

Sixteen states with uninsured rates higher than the national average of 14.2 percent for adults 50 to 64 will see particularly large gains (Exhibit 3).⁴ The states are: Florida, New Mexico, and Texas, where 20.1 percent to 22.5 percent of this age group were uninsured in 2008 and 2009; Alaska, Arizona, California, Georgia, Nevada, and Wyoming, where 16.5 percent to 18.2 percent were uninsured; Louisiana, Mississippi, Montana, Oklahoma, and Tennessee, where 15.3 percent to 15.9 percent were uninsured; and North Carolina and South Carolina where 14.3 percent and 14.5 percent were uninsured.⁵

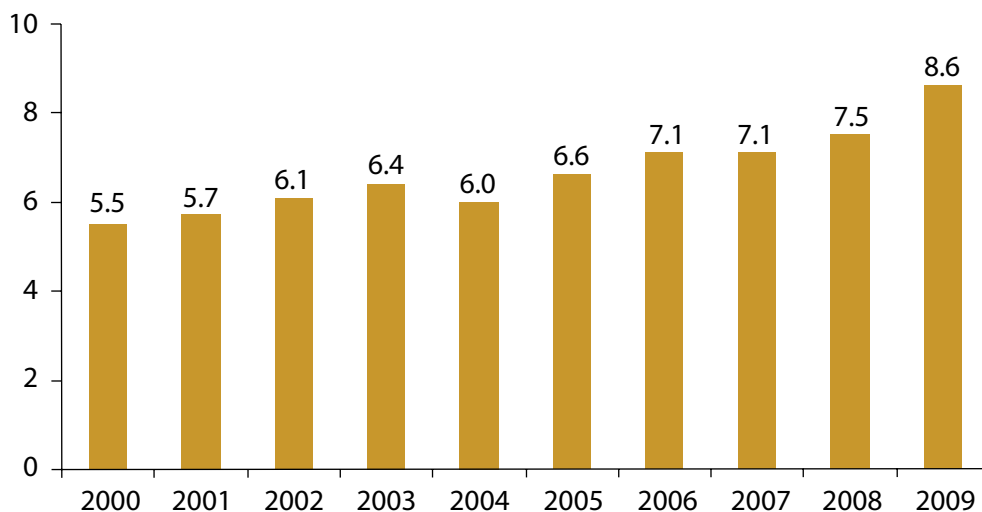
BACKGROUND

Losses in coverage in the 50-to-64-year-old age group have been driven by record high unemployment. Approximately 2.2 million workers age 55 and older were unemployed in November 2010. Unemployed workers between the ages of 55 and 64 had been jobless for an average of almost 45 weeks, the highest average unemployment duration of any age group under age 65 in this time period.⁶ As a result, the number of uninsured people in this age group likely climbed in 2010 as options for affordable health insurance dwindled and family budgets became more constrained.

A loss of employer coverage can be devastating to people in this age group. An analysis of federal data showed that in 2007, nearly two-thirds (64%) of adults ages 50 to 64, or about 35 million people, had at least one chronic health condition, including heart disease, high blood pressure, and diabetes.⁷ In most states, health insurance carriers underwrite insurance policies on the basis of health status and age, among

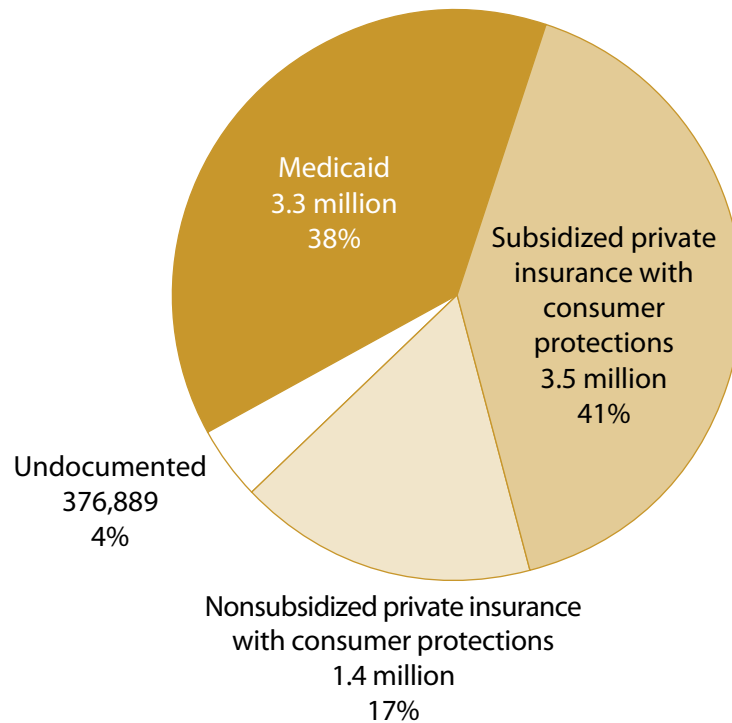
Exhibit 1. 8.6 Million Uninsured Adults Ages 50–64 in 2009, Up by 1.1 Million in Last Year

Millions uninsured, adults ages 50–64



Source: Analysis of the 2001–2010 Current Population Surveys by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

Exhibit 2. Most of the 8.6 Million Currently Uninsured Adults Ages 50–64 Will Gain Coverage Beginning in 2014



8.6 Million Uninsured Adults Ages 50–64 in 2009

Source: Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; estimates of undocumented uninsured adults by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

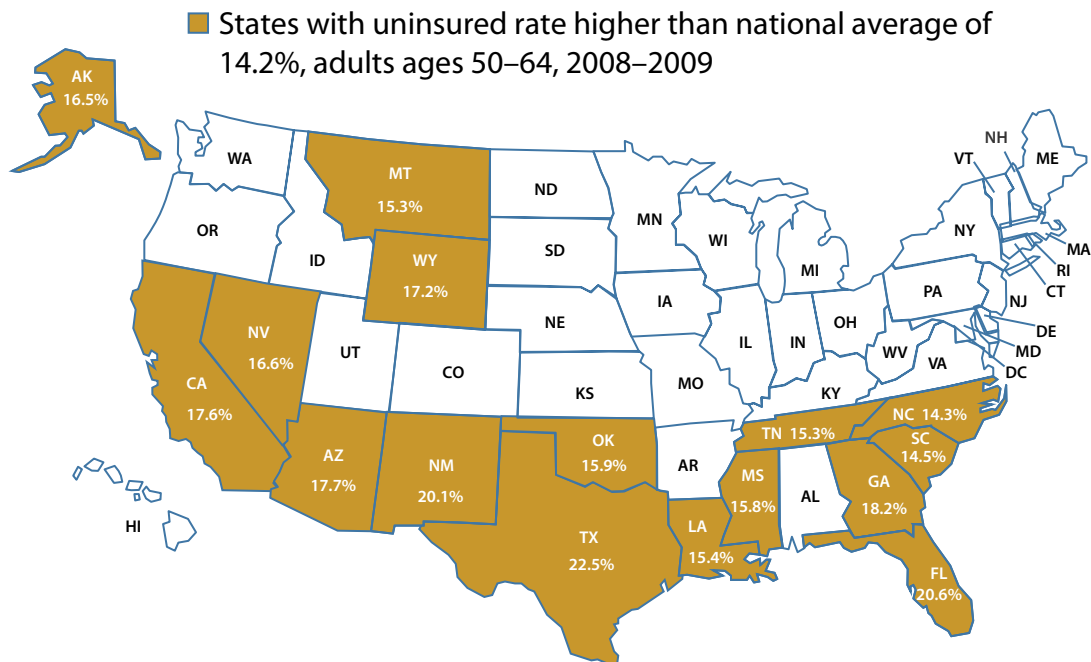
other factors. This means that baby boomers who lose their employer coverage and look for a plan in the individual market are at considerable risk of facing exorbitant premiums, having a condition excluded from their coverage, or being denied insurance altogether. The Commonwealth Fund Biennial Health Insurance Survey found that of the adults ages 50 to 64 who purchased or tried to buy a health plan on the individual insurance market, 45 percent found it difficult or impossible to find a plan that met their needs, 61 percent found it difficult or impossible to find a plan they could afford, and 39 percent were turned down, charged a higher price, or had a condition excluded because of a preexisting condition (Exhibit 4). Nearly 70 percent of older adults never bought a plan.

Lacking health insurance dramatically increases the likelihood that adults in this age group will skip or delay needed health care when they become ill and recommended cancer or other preventive care

screenings. The Commonwealth Fund Survey found that 75 percent of uninsured adults ages 50 to 64 reported not getting needed health care because of the cost, including not filling prescriptions; skipping medical tests, treatments, or recommended follow-up visits; and not seeing a doctor when sick (Exhibit 5). Similarly, nearly half (46%) of uninsured older adults delayed or did not get preventive screenings because of cost, a rate that was more than five times that of older adults with adequate health insurance.

When uninsured adults in their 50s and 60s delay needed health care there are long-term cost implications for the health system and the Medicare program, in particular. Research by Michael McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 had significantly more doctor visits, hospitalizations, and total

Exhibit 3. Adults Ages 50–64 in 16 States with Uninsured Rate Higher Than the National Average Will Particularly Benefit from the Health Reform Law



Note: Uninsured rates are two-year averages, 2008–2009.

Source: Analysis of the March 2009 and 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

medical costs than did previously insured adults, with the difference persisting through age 72.^{8,9}

Going without health insurance or having inadequate insurance can also lead to medical debt and an impaired ability to save for retirement.¹⁰ The Commonwealth Fund 2007 Biennial Health Insurance Survey found that more than half (54%) of uninsured older adults and three-fourths (78%) of underinsured older adults spent 10 percent or more of their income on premiums and out-of-pocket health care costs, compared with 20 percent who were insured all year with adequate coverage (Exhibit 5). Nearly seven of 10 baby boomers who are uninsured and underinsured reported problems paying medical bills or said they were paying off medical debt over time, compared with 23 percent of adults with adequate coverage.¹¹

HOW WILL OLDER ADULTS GAIN HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT?

The Patient Protection and Affordable Care Act of 2010 will provide health insurance to all U.S. citizens starting in 2014 and will significantly improve quality of coverage. There are several ways the legislation will achieve these goals, as follows:

- offering new plans for people with preexisting conditions who cannot get health insurance, beginning in 2010;
- banning lifetime limits on insurance policies, beginning in 2010;
- requiring health plans to insure all who apply, preventing health plans from charging higher premiums to sicker people, and limiting how much premiums can rise by age, beginning in 2014;
- requiring coverage of preventive care and immunizations without cost-sharing, beginning in 2010;

Exhibit 4. Two of Five Adults Ages 50–64 Who Have or Tried to Buy Individual Insurance Were Turned Down, Charged a Higher Price, or Excluded Because of a Preexisting Condition

Adults who have individual coverage or tried to buy it in past three years who:	
Found it very difficult or impossible to find coverage they needed	45%
Found it very difficult or impossible to find affordable coverage	61
Turned down, charged a higher price, or excluded because of a preexisting condition	39
Never bought a plan	69

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

- helping to preserve employer-based coverage for employees retiring between the ages of 55 and 65, beginning in 2010;
- creating a new long-term care insurance program, beginning in 2012;
- significantly expanding Medicaid eligibility to cover all adults with incomes below 133 percent of the federal poverty level, beginning in 2014; and
- creating new state health insurance exchanges with subsidized private insurance for people with low and moderate incomes, up to 400 percent of poverty, beginning in 2014 (Exhibit 6).

Beginning in 2014, the American public will enter a new era in health insurance coverage: loss of a job or a spouse or another life-changing event will no longer mean a loss of health insurance. Regardless of life circumstances, everyone will have health insurance. In addition, several provisions that went into effect in 2010 will provide important transitional support for many adults who have struggled to buy coverage on their own. These early provisions will also help to improve benefits. The provisions of the law that will create stable and comprehensive coverage for adults 50 to 64 are analyzed in order of implementation.

2010: Pre-Existing Condition Insurance Plans (PCIPs)

The estimated 35 million older adults with chronic health problems would likely have difficulty finding an affordable health plan that covered their health problem, if they had to seek coverage on their own. Indeed, of those with chronic health problems, more than

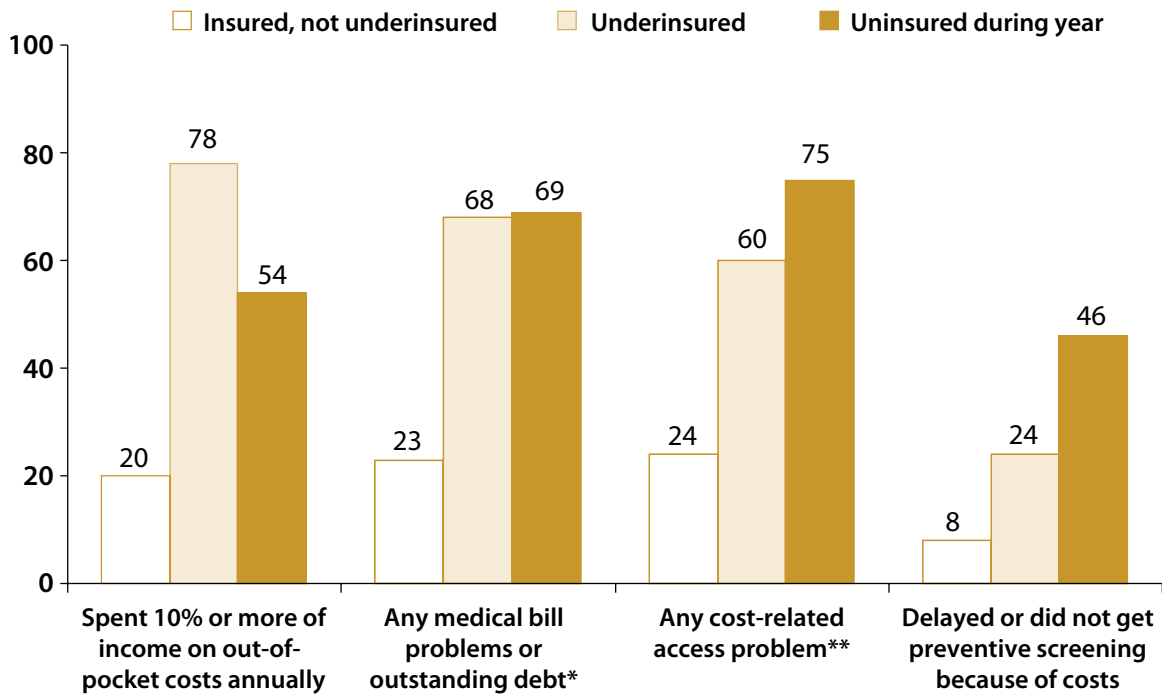
6 million reported being uninsured in 2007.¹² Some have gained coverage through high-risk pools for people with preexisting health problems, which have operated in 35 states for several years.¹³ These pools, however, often impose waiting periods for coverage of preexisting conditions and charge premiums that range from 125 percent to 200 percent above those in the individual market. Thus, they are impractical or unaffordable for most potential enrollees. Only 5 percent of the eligible population are currently enrolled in the pools.

To provide transitional relief, the Affordable Care Act established Pre-Existing Condition Insurance Plans (PCIPs).¹⁴ Now available in all 50 states and the District of Columbia, PCIPs are open to people who have been uninsured for at least six months and who have a health problem that has made it difficult for them to gain health insurance.¹⁵ PCIPs cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. Premiums are set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs are required to cover, on average, no less than 65 percent of medical costs and to limit out-of-pocket spending to the standards defined by health savings accounts—\$5,950 for individuals. They also cannot impose preexisting condition exclusions or waiting periods.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and the cost of claims. Twenty-seven states

Exhibit 5. Seventy-Five Percent of Uninsured Adults Ages 50-64 Reported a Cost-Related Problem Getting Needed Care

Percent of adults ages 50–64



* Not able to pay bills, contacted by collection agency for unpaid medical bills, had to change way of life to pay medical bills, or medical bills/debt being paid off over time.

** Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

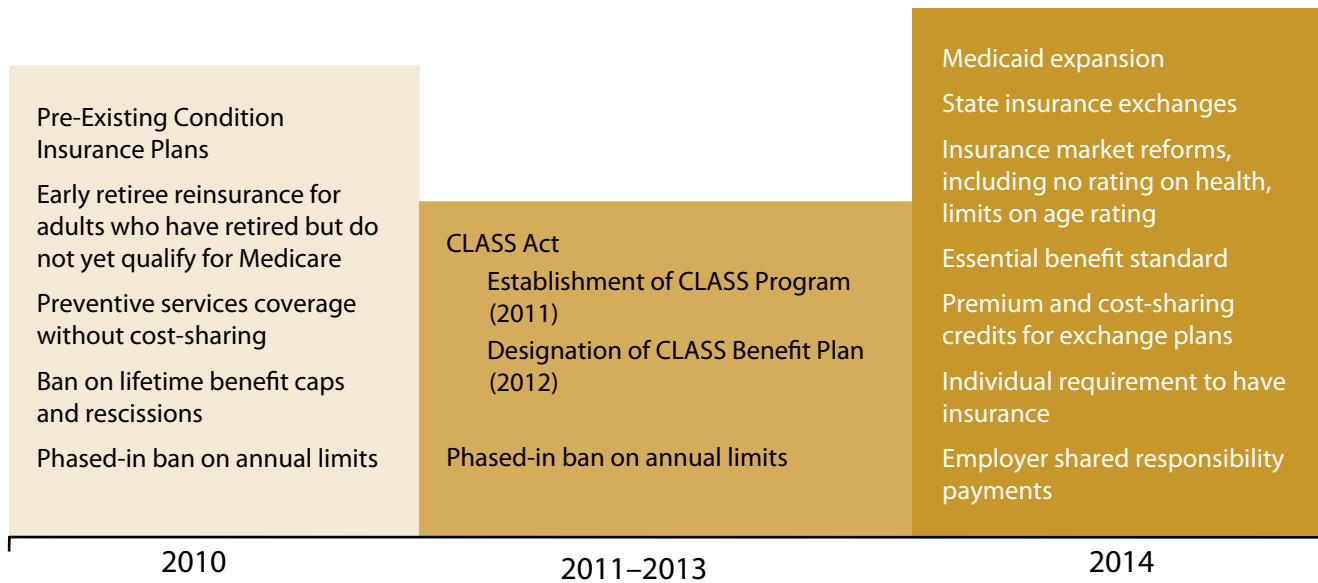
elected to run their own plans and are now enrolling eligible applicants.¹⁶ States have some flexibility in setting the size of the deductible, the level of coinsurance or copayments, and the scope of benefits, so there is variation in PCIPs from state to state. For example, while most plans have a deductible of \$2,500, 15 states offer plans with deductibles at or below \$1,000. Washington and Maryland, in addition, offer plans with out-of-pocket maximums set at \$1,500, well below the federal standard.¹⁷

The federal government is operating PCIPs in the remaining 23 states and the District of Columbia.¹⁸ Federal plans offered in 2010 feature a \$2,500 deductible, \$25 copay for doctor visits, 20 percent coinsurance for other covered in-network benefits, prescription drug coverage with \$4 to \$30 copays for most drugs for the first two prescriptions each month and 50 percent of the cost of subsequent prescriptions, no cost-sharing

for preventive services, no lifetime limit on benefits, and a \$5,950 out-of-pocket maximum for in-network services.¹⁹

Beginning in 2011, the federal government will offer three new PCIPs in those states: the 2011 standard plan, the 2011 extended plan, and the health savings account (HSA) option.²⁰ The 2011 standard plan is expected to have premiums that are 20 percent lower than 2010 premiums and two separate deductibles—a \$2,000 medical deductible and a \$500 drug deductible. Similarly, the 2011 extended plan will also offer separate deductibles of \$1,000 for medical and \$250 for drugs, but will have a slightly higher premium than the 2010 plan. The separate prescription deductibles for both plans should help lower out-of-pocket costs for enrollees who need maintenance drugs. The HSA option will have one deductible of \$2,500 and premiums that are 16 percent lower than 2010 levels.

Exhibit 6. Affordable Care Act Implementation Timeline: Provisions Benefiting Adults Ages 50–64



Source: Commonwealth Fund Health Reform Resource Center: What's In the Affordable Care Act? (Public Law 111-148 and 111-152), www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

Exhibit 7. Uninsured and Underinsured Adults Ages 50–64 Often Miss Recommended Preventive and Cancer Screenings

	Total (%)	Number (in millions)	Uninsured anytime (%)	Insured all year	
				Underinsured (%)	Not underinsured (%)
Adults ages 50–64	—	53.2	17%	18%	65%
Did not receive a blood pressure test (past year)	7	3.8	22	6	4
Did not receive a cholesterol screening (past 5 years)	17	9.3	38	18	12
Did not receive a mammogram (females past 2 years)	25	6.8	55	31	14
Did not receive a pap smear (females past 3 years)	25	7.0	48	31	17
Did not receive a colonoscopy (past 5 years)	47	25.1	72	50	40

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Exhibit 8. Distribution of 8.6 Million Uninsured Adults Ages 50–64 by Federal Poverty Level and Provisions of the Affordable Care Act

Uninsured adults ages 50–64

Federal poverty level	Percent	Number uninsured	Premium cap as a share of income	Cost-sharing cap (share of enrollee's health costs)
<133% FPL	38%	3,260,216	Medicaid	Medicaid
133%–149% FPL	4%	369,574	3.0%–4.0%	6%
150%–199% FPL	12%	1,028,636	4.0%–6.3%	13%
200%–249% FPL	9%	766,794	6.3%–8.05%	27%
250%–299% FPL	7%	563,391	8.05%–9.5%	30%
300%–399% FPL	9%	763,049	9.5%	30%
Subtotal (133%–399% FPL)	41%	3,491,444	3.0%–9.5%	6%–30%
≥400% FPL	17%	1,437,118	n/a	30%
Undocumented	4%	376,889		
Total	100%	8,565,667	n/a	n/a

Source: Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; Commonwealth Fund Health Reform Resource Center: What's In the Affordable Care Act? (Public Law 111–148 and 111–152), www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

Prescription drug coverage will still be available with \$4 to \$30 copays for the first two prescriptions per month in the 2011 extended and HSA plans while the 2011 standard plan will offer coverage with \$4 to \$40 copayments for the first two prescriptions of most drugs each month. All three plans will cover 50 percent of the cost of subsequent prescriptions.²¹ Additionally, the department of health and human services (HHS) will establish a child-only rate for individuals 18 years old and younger enrolled in the PCIPs. States that are running their own PCIPs are also expected to make changes in their plans in 2011.

The HHS secretary will have \$5 billion to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. Enrollment in the PCIPs as of November 1, 2010, was only 8,011 individuals, but is expected to rise with increased awareness of the plans.²² The plans are eventually expected to cover between 175,000 and 400,000 people over their three-and-a-half years of operation.²³

2010: Bans on Health Benefit Limits and Rescissions

More than 100 million people in the United States are enrolled in health plans—either through their employers or through the individual market—that limit payment to enrollees who become very sick or injured.²⁴ About 102 million people have health insurance policies that feature limits on the amount their plans will pay over a lifetime and 18 million have limits on the amount their plans will pay annually.²⁵ The majority of people who have benefit limits on their plans will not exceed them. Approximately 20,000 people of the 100 million who have plans with benefit limits are estimated to incur health expenses that are higher than their limits each year. Still, older adults, because of their higher rates of chronic health problems, are more at risk than younger people of exceeding benefit limits. In addition, the limits can create enormous anxiety for people who become sick and for their family members.

Lifetime limit ban. Starting on September 23, 2010, the Affordable Care Act prohibits all health plans from imposing lifetime limits on the amount their plans will pay in benefits. The ban applies to all employer plans, including self-insured (i.e., employers pay benefits directly to employees) or fully insured (i.e., employers purchase health insurance for employees from an insurance company), and all plans sold in the individual insurance market. It applies to new plans and “grandfathered plans,” that is, those that were in existence when the Affordable Care Act was signed into law on March 23, 2010.²⁶ For people who exceed their lifetime limit before September 23, health plans must serve notice that the lifetime limit no longer applies and provide an enrollment period for people who have since disenrolled from the plan.

Phased-in restrictions on annual limits. The Affordable Care Act will prohibit all health plans, except grandfathered plans sold on the individual market, from imposing annual limits in 2014. Restrictions on annual limits will increase gradually between 2010 and 2013, according to the following schedule:

- between September 23, 2010, and September 23, 2011, plans cannot impose annual limits on health benefits of less than \$750,000;
- between September 23, 2011, and September 23, 2012, plans cannot impose annual limits of less than \$1.25 million; and
- between September 23, 2012, and January 1, 2014, plans cannot impose annual limits of less than \$2 million.

The Affordable Care Act will also ban insurance rescissions, which is a significant development for older adults. Insurance companies selling in the individual market have been known to investigate the medical records of enrollees who become sick to determine whether there is any cause to rescind, or retroactively cancel their policies. A 2009 investigation by the House Energy and Commerce Committee found that between 2003 and 2007, three insurance companies

rescinded the insurance policies of nearly 20,000 people, many for reasons unrelated to the patient’s diagnosis that triggered the investigation.²⁷ Because older adults have higher rates of health problems, they are particularly at risk of a rescission.

Starting on September 23, 2010, the Affordable Care Act prohibits all health insurance plans from rescinding coverage once an enrollee is covered under a plan, except in the case of an individual who has performed an act or practice that constitutes fraud or who makes an intentional misrepresentation of material fact.²⁸ The ban applies to all employer plans, including self-insured plans, and all plans sold on the individual insurance market. It also applies to both new plans and grandfathered plans. In the case of rescissions that are permissible under the new rules, health plans must provide at least 30 days’ notice to enrollees prior to policy cancellation.

2010: Required Coverage of Preventive Care and Immunizations Without Cost-Sharing

The Commonwealth Fund Biennial Health Insurance Survey found that millions of adults ages 50 to 64 did not get recommended preventive care in 2007, such as screenings for colon or breast cancer (Exhibit 7). Older adults who were either uninsured or underinsured were the most likely to forgo preventive screenings. Nearly three-quarters (72%) of uninsured and half of underinsured adults ages 50 to 64 did not receive a colonoscopy in the past five years. Similarly, more than half (55%) of uninsured and 31 percent of underinsured women in that age group said they had not had mammogram in past two years.

Beginning in 2010, the Affordable Care Act will help make preventive services affordable for older adults by requiring health plans to cover recommended preventive services without cost-sharing. The requirements apply to both group and individual market plans, but they do not apply to grandfathered plans.

New guidelines for preventive care and screenings for women will be released by HHS by August 1, 2011.

For insurance plan years beginning on or after September 23, 2010, all non-grandfathered health plans will be required to cover the following services recommended by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention without cost-sharing from in-network providers:²⁹

- blood pressure and cholesterol screening;
- breast cancer screening every one to two years for women ages 40 and older;
- cervical cancer screening;
- colorectal cancer screening;
- diabetes screening;
- osteoporosis screening for all women 65 and older, and 60 and older for those at high risk;
- depression screening;
- annual flu vaccines for adults 50 and older; and
- pneumonia vaccine for adults 65 or older.

Older adults in individual market plans will likely see the biggest improvements in their coverage as a result of the new provisions. While the vast majority (85%) of employer health plans cover preventive services without having to meet a deductible, there is much more variability in coverage of, and cost-sharing for, preventive services in plans sold through the individual insurance market.³⁰

Research has shown that increasing use of preventive care services will save lives. For example, increasing the rate of colon cancer screening among adults ages 50 and older from the current rate of 48

percent to 90 percent could save 14,000 lives annually.³¹ In addition, 12,000 lives might be saved as a result of increasing flu vaccines among adults age 50 and older.

2010: Early Retiree Health Benefits Reinsurance Program for Employers

Many large employers, as well as federal, state, and local governments, have provided health benefits for their retired employees since the 1950s.³² However, there has been a substantial decline in the number of companies offering such benefits over the past two decades, driven by rising health care costs and a change in the way private employers must report retiree health liabilities on their annual financial reports. In 2009, slightly more than one-quarter (28%) of companies with 500 or more employees offered health benefits to employees that retire between the ages of 55 and 65, down from 46 percent in 1993.³³ Employers that continue to offer early retiree health benefits have tried to lower their costs by making it more difficult for employees to qualify—by increasing age limits or tenure, reducing premium contributions, and eliminating the benefit for new hires. Public sector employers, which are now facing an accounting change similar to private companies and substantial state budget challenges, are also tightening eligibility for benefits.

Beginning in 2014, people who retire before the age of 65 will be able to purchase health insurance through the new insurance exchanges, with tax credits for those with low and moderate incomes. To encourage employers to maintain their retiree health benefits until 2014, the Affordable Care Act includes a \$5 billion temporary program that will pay part of the cost of health benefits to employers for early retirees ages 55 to 64 when the retiree, or his or her spouse or dependent, incurs high health care costs.³⁴ The program ends in 2014.

All employers are eligible to participate, including self-insured or fully insured private companies, state and local governments, nonprofits, religious organizations, and unions operating employee benefit plans. Employers who participate in the program may receive reimbursement for up to 80 percent of health

care costs incurred by a retired employee or dependent family member of more than \$15,000 and less than \$90,000 in a given plan year. Applicable costs include both the plan's costs and any out-of-pocket expenses paid by the employee.³⁵

Employers may use reimbursements to reduce premiums or offset the cost of premium increases as well as lower beneficiary premium contributions, copayments, deductibles, and coinsurance. Similar reinsurance programs have been effective at lowering premiums. For instance, New York's Healthy NY insurance program for low-wage workers and small businesses with low-wage workforces uses a similar reinsurance program that has succeeded in lowering premiums for participating small businesses by 15 percent to 30 percent below premiums in the small-group market.³⁶

HHS began accepting applications from employers for the early retiree reinsurance program on June 29, 2010, with the program retroactive to June 1. About 3,600 employers, including Fortune 500 companies, all major unions, and government entities in all 50 states and the District of Columbia, are now participating in the program and able to submit claims and receive reinsurance payments.³⁷

2011–2013: Community Living Assistance Services and Supports (CLASS) Program

An estimated 10.9 million Americans living at home or in community settings, such as assisted living facilities, are in need of long-term care services to perform daily activities, like bathing and eating.³⁸ An additional 1.8 million adults live in nursing homes. These numbers will likely grow substantially as the population ages: adults ages 65 and older have more than a 70 percent chance of needing long-term care services before they die.³⁹

Long-term care services can include a wide range of health and social assistance and may be provided in a private home, assisted living facility, or nursing home.⁴⁰ The average cost of personal unskilled care at home was \$19 per hour in 2009, with the average person needing about 17 hours per week at an annual cost of about \$16,800 a year. The cost of assisted living

facilities averaged about \$33,900 a year in 2009 and a semiprivate room in a nursing home was \$66,886 per year. While Medicaid pays for about half the long-term care services provided in the U.S. each year, eligibility varies widely by state and beneficiaries must spend down their savings before becoming eligible. Medicare finances about one-quarter of long-term care services, but financing is limited to post-acute care services. About 18 percent of long-term care services are paid by families out-of-pocket.

Although there is a market for private long-term care insurance for individuals and employers who wish to offer it to employees, only about 10 percent of adults age 50 and older, or 6 million to 7 million people, have a long-term care policy.⁴¹ While there has been considerable growth in the number of employers that offer long-term care benefits to their employees over the last decade and a half—about one-third of adults with a policy had it through an employer in 2007, up from 3 percent in the mid-1990s—few employers contribute to premiums. Policies directly purchased by individuals are expensive and become more costly as people age. In addition, low demand for the policies may reflect widespread confusion about Medicare coverage. A survey by AARP found that almost four of five respondents between the ages of 45 and 64 believed that Medicare pays for long-term care services.⁴²

The Affordable Care Act establishes a new long-term care insurance program on January 1, 2011, and directs the secretary of HHS to designate a benefit plan for the program no later than October 1, 2012. Under the program, employers and self-employed individuals eventually will be able to elect to participate in a national, voluntary insurance program for the purchase of community living assistance services and supports (CLASS). Participating employers will be required to automatically enroll employees 18 and older, but employees will have the option to opt out. Premiums will be paid through payroll deductions. The HHS secretary is required to establish an enrollment mechanism for self-employed people, those with more than one employer, and those working in companies that do not participate in the program.

Each year the secretary will establish premiums for the program based on a 75-year actuarial estimate of the cost of the program. Premiums for enrollees will vary based on age at enrollment, but not on the basis of health and there will be no preexisting condition exclusions. Premiums will not change over the period of enrollment for an individual, unless it is determined that they will be insufficient to cover the future benefits of the program. However, active enrollees age 65 and older who have paid premiums for at least 20 years and are not employed will be exempt from premium increases. People with incomes below the poverty level or students ages 18 to 21 will pay no more than \$5 in premiums, albeit with inflationary increases over time. Upon loss of full-time student status, premiums will increase to the level of individuals of the same age.

The program will provide eligible enrollees who have paid premiums for at least 60 months a cash benefit of at least \$50 per day on average to purchase nonmedical services and supports necessary to maintain community residence. To receive benefits, an enrollee must have a functional limitation that is expected to last for at least 90 days.

The Congressional Budget Office estimates that initial premiums will be \$123 per month, indexed to inflation in later years, and about 10 million people, or 3.5 percent of the adult population, will enroll by 2019.⁴³ This premium estimate assumes that the program would pay an average benefit of \$75 per day and have sufficient premium revenues to ensure solvency over 75 years.⁴⁴ The Centers for Medicare and Medicaid Services (CMS) estimate higher monthly premiums: an average \$240 per month for a \$50 per day benefit.⁴⁵ CMS's higher premium estimates stem from a projection of lower participation (2 percent of the adult population) and a larger pool of enrollees with health problems.

2014: Medicaid Expansion

Beginning in 2014, the Affordable Care Act expands eligibility for Medicaid for all legal residents with incomes up to 133 percent of the federal poverty level—about \$14,404 for a single adult or \$29,327 for

a family of four. This represents a substantial change in Medicaid's coverage of adults. Although several states have expanded eligibility for parents of dependent children, in most states income eligibility thresholds for parents are well below the federal poverty level.⁴⁶ In addition, adults who do not have children are not currently eligible for Medicaid, regardless of income, in most states.

Of all the provisions in the Affordable Care Act, the Medicaid expansion will potentially have the largest impact on reducing the number of uninsured baby boomers. Of all uninsured older adults, nearly two of five (38%) are legal residents in families with incomes less than 133 percent of poverty (Exhibit 5).⁴⁷ The expansion has the potential to provide health insurance to up to an estimated 3.3 million uninsured older adults in that income range. Approximately 207,666 uninsured adults ages 50 to 64 with incomes less than 133 percent of poverty are undocumented immigrants and would not be eligible for Medicaid.⁴⁸

2014: Placing Bans and Limits on Charging Higher Premiums Because of Health and Age

Currently, in most states older adults who attempt to purchase coverage on their own encounter considerable challenges in the individual insurance market. Insurance companies will underwrite potential buyers on the basis of their health and age, in addition to other factors. Consequently, adults in the 50-to-64 age group, even if they are in good health, may find policies with much higher premiums and cost-sharing than those offered to younger people. These plans may also exclude preexisting conditions, such as back problems or cancer, from coverage.

One of the most important changes the Affordable Care Act makes for this age group is a set of insurance market reforms that: guarantees they will be offered a health plan when they apply, prohibits insurance carriers from including preexisting condition clauses, and places bans or limits on how much premiums can vary based on health, age, or other factors.

Beginning in January 2014, health plans may not impose any exclusions for preexisting conditions.

This requirement applies to all non-grandfathered plans and grandfathered group plans, but not grandfathered plans sold on the individual market (although people could switch out of their grandfathered plans and buy new plans). In addition, all non-grandfathered insurance carriers are required to accept every individual who applies for coverage.

In addition, starting in January 2014, premiums charged by a health insurance carrier may not vary by health status: people in poor health will be charged the same premiums as those in good health. The law also places limits on how much premiums may vary by age. Currently, premiums can vary widely by age in the individual and small-group markets.⁴⁹ The Affordable Care Act restricts variation in premiums based on age to no more than 3-to-1. That is, the highest premium charged for adults can be no more than three times the lowest premium charged. Premiums may also vary by whether an individual or family is covered and by the geographic or “rating area” in which the coverage is offered, as established by each state or HHS. For tobacco users, the highest premium may be no more than 1.5 times the premium for a nonsmoker. These limits on premium variation do not apply to grandfathered plans.

2014: Essential Health Benefits Standard

People who must shop for insurance policies on their own are likely to find wide variation in the scope of medical services covered and the amount of potential out-of-pocket costs. Starting in 2014, all health plans sold through the new state insurance exchanges and in the individual and small-group markets will be required to provide a federally determined essential benefit package similar in scope to a typical employer plan. Such a benefit standard will vastly improve the ability of consumers and small businesses to compare prices of health plans.⁵⁰ The essential benefit package, in combination with other Affordable Care Act consumer protections such as bans on annual and lifetime benefit limits, will improve access to timely preventive services and protect against catastrophic costs in the event of a serious accident or injury.

The essential benefit package will be determined by the HHS secretary and must include, at a minimum: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; vaccines; chronic disease management; and pediatric services, including vision and oral care. The scope of the benefits provided must be equivalent to the scope of benefits provided under the typical employer-sponsored plan. Health plans may provide benefits in addition to those included in the essential health benefits package. The benefit requirements do not apply to grandfathered plans or self-insured employer plans.

Adults and small businesses purchasing coverage through the exchanges and the individual and small-group insurance markets may choose among health plans with the essential benefit package but with four different levels of cost-sharing: plans that cover an average 60 percent of an individual’s total medical costs per year (bronze plan), 70 percent of medical costs (silver plan), 80 percent of medical costs (gold plan), and 90 percent of medical costs (platinum plan). Out-of-pocket costs are limited to \$5,950 for single policies and \$11,900 for family policies.

2014: Insurance Exchanges and Tax Credits to Reduce Premiums and Out-of-Pocket Costs

The Affordable Care Act requires each state to establish a new health insurance exchange for individuals and another for small employers, or a single exchange for both individuals and small employers.⁵¹ States can set up their own exchanges or band with other states to establish regional exchanges. States can also decline to establish an exchange and the federal government will do it for them. The individual and small-group markets will continue to function outside the exchange, but the new insurance market regulations will apply to plans sold inside and outside the exchanges.

The exchanges will provide a new regulated marketplace in which people without access to

affordable and comprehensive employer coverage can purchase insurance. People with employer coverage who spend more than 9.5 percent of their income on premiums or those with plans that covers less than 60 percent, on average, of their medical costs are eligible to purchase coverage through the exchanges.

For the first time, people who must buy coverage on their own will be eligible for a federal tax credit to help pay for the cost of premiums for plans sold through the exchanges. Premium credits will be tied to the silver plan and will cap contributions for individuals and families from 2 percent of income for those with incomes up to 133 percent of the federal poverty level (\$14,404 for a single adult or \$29,327 for a family of four) and gradually increase to 9.5 percent of income for those with incomes at 300 percent to 400 percent of the poverty level (\$43,320 for a single person and \$88,200 for a family of four) (Exhibit 8).

Older adults with low and moderate incomes will also benefit from cost-sharing credits that effectively reduce out-of-pocket spending under the silver plan to an average 6 percent of total costs for those with incomes up to 150 percent of poverty (\$16,245 for a single person and \$33,075 for a family four) (Exhibit 8). Out-of-pocket costs will be capped at a maximum of 13 percent of total costs for those with incomes up to 200 percent of poverty (\$21,660 for a single person and \$44,100 for a family of four) and 27 percent for those with incomes up to 250 percent of poverty (\$27,075 for a single person and \$55,125 for a family of four). In addition, out-of-pocket expenses will be capped for families earning between 100 percent and 400 percent of poverty from \$1,983 for individuals and \$3,967 for families up to \$3,967 for individuals and \$7,933 for families.

Subsidized private coverage has the potential to provide health insurance for up to 3.5 million uninsured adults ages 50 to 64 with incomes between 133 percent and 400 percent of poverty (Exhibit 2).⁵² An estimated 149,000 uninsured older adults in that income range are undocumented immigrants and would not be eligible for federal subsidies under the Affordable Care Act.⁵³

CONCLUSION

Beginning in 2014, the American public will enter a new era in health care: loss of a job or a spouse or another life-changing event will no longer mean a loss of health insurance. Regardless of life circumstances, everyone will have access to comprehensive health insurance coverage. This will be achieved by a substantial expansion in eligibility for Medicaid benefits, subsidized private health insurance with comprehensive benefits through the new insurance exchanges, and new consumer protections in the insurance markets. At least 32 million uninsured people are projected to gain coverage by 2019. Of these, approximately 17 percent will be between the ages of 50 and 64.

Prior to 2014, many adults in the 50-to-64 age group will benefit from early provisions in the law, many of which went into effect in 2010. These include preexisting condition insurance plans, which are available in all 50 states and the District of Columbia; new coverage of preventive care and flu vaccines without cost-sharing; and support to employers to help maintain health benefits for early retirees.

Provisions in the health reform law will substantially reduce both the share of 50-to-64-year-olds who are without health insurance (15%) and the share who have health insurance but such skimpy benefits that they are underinsured (18%). Of the 8.6 million who were uninsured in 2009, up to 6.8 million may gain subsidized insurance through Medicaid or the insurance exchanges. Another 1.4 million with higher incomes would have access to health insurance plans with comprehensive benefits through the exchanges where they cannot be excluded from coverage or face higher premiums because of preexisting health conditions. Finally, the estimated 9.7 million older adults who are underinsured will gain more comprehensive benefit packages and greater protection from out-of-pocket costs and medical bills. The Affordable Care Act will help ensure that 50-to-64-year-olds who lose employer health benefits—whether as a result of a lay-off or early retirement—have ready access to affordable and comprehensive insurance that will help them maintain their health while protecting their retirement savings.

NOTES

- 1 Analysis of the March 2009 and 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.
- 2 C. Schoen, S. R. Collins, J. L. Kriss, and M.M. Doty, “How Many are Underinsured: Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* Web Exclusive, June 10, 2008, w298–w309.
- 3 Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
- 4 Uninsured rates by states are shown as two-year averages to account for low sample sizes in some states. Over 2008 to 2009, 14.2 percent of 50-to-64 year olds were uninsured nationally. In 2009, 15 percent of older adults were uninsured.
- 5 Analysis of the March 2009 and 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund. Uninsured rates are two year averages for 2008–2009.
- 6 Bureau of Labor Statistics, News Release: The Employment Situation–November 2010 (Wash., D.C.: U.S. Department of Labor, Dec. 3, 2010) <http://www.bls.gov/news.release/pdf/empisit.pdf>; M. Rich, “For the Unemployed Over 50, Fears of Never Working Again,” *The New York Times*, Sept. 19, 2010. The number of unemployed workers is seasonally adjusted; the duration of unemployment estimates are not seasonally adjusted.
- 7 Analysis of the MEPS 2007 by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund. An individual is counted as having a chronic condition if he or she has one of eight chronic conditions: diabetes, high blood pressure, asthma, heart disease, heart attack, stroke, arthritis, or emphysema.
- 8 J. M. McWilliams, E. Meara, A. M. Zaslavsky et al., “Use of Health Services by Previously Uninsured Medicare Beneficiaries,” *New England Journal of Medicine*, July 12, 2007 357(2):143–53; S. Collins, K. Davis, C. Schoen, M. M. Doty, and J. L. Kriss, *Health Coverage for Aging Baby Boomers: Findings from the Commonwealth Fund Survey of Older Adults*, (New York: The Commonwealth Fund, Jan. 2006).
- 9 McWilliams, Meara, Zaslavsky et al., “Use of Health Services,” 2007.
- 10 Collins, Davis, Schoen, Doty, and Kriss, *Health Coverage for Aging Baby Boomers*, 2006.
- 11 Medical bill problems reported by survey respondents included not being able to pay bills, being contacted by collection agency for unpaid medical bills, having to change their way of life to pay medical bills, or paying off medical bills or debt over time.
- 12 Analysis of the MEPS 2007 by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund. An individual is counted as having a chronic condition if he or she has one of eight chronic conditions: diabetes, high blood pressure, asthma, heart disease, heart attack, stroke, arthritis, or emphysema.
- 13 J. Hall and J. Moore, *Realizing Health Reform’s Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010).
- 14 Ibid.
- 15 Department of Health and Human Services, “Pre-Existing Condition Insurance Plan Program,” Interim Final Rule with Comment Period, July 29, 2010.
- 16 These are: Alaska, Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, and Wisconsin. See <http://www.pcip.gov/StatePlans.html> for more information on state-run PCIPs.
- 17 Hall and Moore, *Realizing Health Reform’s Potential*, 2010.
- 18 These are: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, D.C., West Virginia and Wyoming. See <http://www.pcip.gov/StatePlans.html> for more information about the federal PCIP.

- ¹⁹ Mail order prescription drug coverage is also available for a \$10 to \$75 copayment for a 90-day supply of most brand-name drugs.
- ²⁰ HealthCare.gov, Fact Sheet: New Plan Options for Federally Administered Pre-Existing Condition Insurance Plan in 2011, U.S. Department of Health and Human Services, Nov. 5, 2010. See http://www.healthcare.gov/news/factsheets/new_plan_options_2011.html; <http://www.pciplan.com/forms/pdfs/2011BenefitsSummary.pdf>
- ²¹ Mail order prescription drug coverage will continue to be available for the 2011 plan year. A 90-day supply of most drugs will be available for a copayment of \$10 to \$75 for the 2011 extended plan and the HSA plan, and for a copayment of \$10 to \$100 for the 2011 standard plan.
- ²² See http://www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html.
- ²³ Hall and Moore, *Realizing Health Reform's Potential*, 2010; Department of Health and Human Services, "Pre-existing Condition Insurance Plan Program," Interim Final Rule, July 30, 2010, <http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf>; Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.
- ²⁴ Department of Treasury, Department of Labor, and Department of Health and Human Services, "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," Interim Final Rules, June 21, 2010, <http://www.hhs.gov/ociio/regulations/index.html#patients>.
- ²⁵ For more detail, see S. R. Collins, S. D. Rustgi, M. M. Doty, *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, July 2010).
- ²⁶ Under interim final regulations issued by the Departments of Health and Human Services, Labor, and Treasury in June 2010, health plans will lose their grandfathered status if they make significant reductions in coverage or increases in cost-sharing. The Departments estimate that by 2013 between 49 percent to 80 percent of small employers (fewer than 100 employees), 39 percent to 69 percent of large employers, and 40 percent to 67 percent of individual market plans will relinquish their grandfathered status. See S. R. Collins, "Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance," Commonwealth Fund Blog, June 22, 2010; and Department of the Treasury, Department of Labor, Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," <http://www.hhs.gov/ociio/regulations/grandfather/index.html>.
- ²⁷ U.S. House of Representatives Committee on Energy and Commerce, "Supplemental Information Regarding the Individual Insurance Market," Memorandum to Members and Staff of the Subcommittee on Oversight and Investigations, June 16, 2009.
- ²⁸ Department of Treasury, Department of Labor, and Department of Health and Human Services, "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," Interim Final Rules, June 21, 2010, <http://www.hhs.gov/ociio/regulations/index.html#patients>.

- ²⁹ The Departments of Health and Human Services, Labor, and Treasury issued interim final regulations on the preventive care provision in July 2010 that clarified that the new coverage provisions apply to care obtained from in-network providers. In addition, if preventive services are provided during an office visit and billed separately, there would be no cost-sharing for the services delivered, but the office visit could be subject to cost sharing. Alternatively, when preventive services are not billed separately during an office visit, and the services are the primary purpose of the visit, then the office visit would not be subject to cost-sharing. However, if a patient obtains preventive services during an office visit for reasons other than the preventive care service, the office visit could be subject to cost-sharing. See Department of the Treasury, Department of Labor, and Department of Health and Human Services, “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act,” July 19, 2010, available at <http://www.healthcare.gov/center/regulations/prevention/regs.html>.
- ³⁰ Department of the Treasury, Department of Labor, and Department of Health and Human Services, “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act,” July 19, 2010, available at <http://www.healthcare.gov/center/regulations/prevention/regs.html>.
- ³¹ Department of the Treasury, Department of Labor, and Department of Health and Human Services, “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act,” July 19, 2010, p.28. available at <http://www.healthcare.gov/center/regulations/prevention/regs.html>.
- ³² P. Fronstin, *Implications of Health Reform for Retiree Health Benefits*, (Wash., D.C.: Employee Benefit Research Institute, Jan. 2010).
- ³³ Ibid.
- ³⁴ Department of Health and Human Services, “Early Retiree Reinsurance Program, Interim Final Rule with Comment Period, Federal Register,” Vol.75, No. 86, May 5, 2010, <http://www.errp.gov/>.
- ³⁵ Costs incurred prior to June 1, 2010 do not qualify for reimbursement, however they can be counted toward the \$15,000 threshold, so long as those costs were incurred during a plan year that will end after June 1, 2010.
- ³⁶ The current reinsurance program pays insurers 90 percent of total expenses for enrollees incurring costs between \$5,000 and \$75,000. See Burns and Associates, *Independent Report on the Healthy NY Program for Calendar Year 2009, Final Report*, (Phoenix, Ariz.: Burns and Associates, Jan. 2010), <http://www.ins.state.ny.us/website2/hny/reports/hny2009rep.pdf>; K. Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (New York: The Commonwealth Fund, Nov. 2001); and K. Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do*, (New York: Russell Sage Foundation, June 2006).
- ³⁷ U.S. Department of Health and Human Services, Early Retiree Reinsurance Program, <http://www.errp.gov/>.
- ³⁸ H. S. Kaye, C. Harrington, M. P. LaPlante, “Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?” *Health Affairs*, Jan. 2010 29(1):11–21.
- ³⁹ A. Dobson, J. E. DaVanzo, A. El-Gamil et al., “Post-Acute Care and Long-Term Care: A Complex Relationship,” prepared for the Long-Term Care Interest Group Colloquium, June 29, 2010, <http://www.academyhealth.org/Communities/Communities.cfm?ItemNumber=4918&navItemNumber=2034>; P. Kemper, H. L. Komisar, and L. Alecxih, “Long-Term Care Over an Uncertain Future: What Can Future Retirees Expect?” *Inquiry*, Dec. 2005 42(4):335–50.
- ⁴⁰ J. Mulvey and K. J. Colello, *Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)*, (Wash., D.C.: Congressional Research Service, July 20, 2010).
- ⁴¹ Ibid.

- ⁴² Ibid.
- ⁴³ Letter to the Honorable Tom Harkin, Additional Information on the CLASS Program, Congressional Budget Office, Nov. 25, 2009, available at http://cbo.gov/ftpdocs/107xx/doc10768/CLASS_Additional_Information_Harkin_Letter.pdf.
- ⁴⁴ Mulvey and Colello, *Community Living Assistance Services and Supports*, 2010.
- ⁴⁵ R. S. Foster, “Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended,” Centers for Medicare and Medicaid Services, Office of the Actuary, Apr. 22, 2010, http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.
- ⁴⁶ 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).
- ⁴⁷ Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.
- ⁴⁸ Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
- ⁴⁹ National Association of Insurance Commissioners and Center for Insurance Policy Research, *Health Insurance Rate Regulation*, http://www.insurance.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.
- ⁵⁰ L. J. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Wash., D.C.: The Urban Institute, Apr. 2009).
- ⁵¹ T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, (New York: The Commonwealth Fund, Sept. 2010); T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, (New York: The Commonwealth Fund, July 2010).
- ⁵² Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.
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