Newly enacted national health reform will begin, almost immediately, to transform the U.S. health care system in ways large and small. The changes will increase the number of people with health insurance, and affect how many of us obtain coverage, how care is paid for and delivered, and how it is regulated. The Patient Protection and Affordable Care Act of 2010 preserves the current private–public system of employer-based coverage, Medicare, and Medicaid and creates income-based subsidies to make coverage affordable to low- and middle-income families without employer coverage. Many major features of reform begin to take effect in 2010:

- **New insurance rules:** Insurance companies will be banned from rescinding people’s coverage when they get sick, and from imposing yearly and lifetime caps on coverage.
- **High-risk pool:** People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool. Premiums will be based on the average health status of a standard population. Annual out-of-pocket costs will be capped at $5,950 for individuals and $11,900 for families.

- **Protection for children:** Insurers can no longer deny health coverage to children with preexisting conditions or exclude their conditions from coverage.
- **Coverage for young adults:** Parents will be able to keep their children on their health policies until they turn 26.
- **Small-business tax credits:** Small businesses (fewer than 25 employees and average wages under $50,000) that offer health care benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.
- **Preventive care:** All new group and individual health plans will be required to provide free preventive care for proven preventive services. In 2011, Medicare also will provide free preventive care.
- **Early retirees:** A temporary reinsurance program will help offset the costs of expensive premiums for employers providing retiree health benefits.
- **“Doughnut hole” rebates:** Medicare will provide $250 rebates to beneficiaries who hit the Part D prescription drug coverage gap known as the “doughnut hole.”
- **Annual review of premium increases:** Health insurers will be required to submit justification for premium increases to the federal and relevant state governments before they take effect, and to report the share of premiums spent on non-medical costs.
- **Access to care:** Funding will be increased by $11 billion over five years for community health centers and the National Health Services Corps to serve more low-income and uninsured people.
Over the next decade, health reform will help all Americans—young, old, poor, middle-income, working, and unemployed—get and keep affordable health care coverage, while putting in place mechanisms to slow the growth in health care costs and improve quality. Following are key questions that journalists and others might have about how reform will change the way health care is paid for and delivered.

1 How will health reform help more people obtain coverage and access to care? Who will be helped?

Both health care coverage and access to care will be expanded under a mixed private–public system of health care financing.
**The uninsured**

By 2019, an additional 32 million uninsured will be covered, increasing the proportion of the population with insurance to 94 percent. Without health reform, the number of uninsured—now at 46 million—would have risen to an estimated 54 million by 2019. Instead that number will fall to 23 million, or about 6 percent of the population.

About 16 million uninsured people with incomes below 133 percent of the federal poverty level will be covered by Medicaid. They also may find a greater number of doctors who accept Medicaid, because Medicaid’s often low reimbursement rates for primary care will be increased to the same level as Medicare’s in 2013 and 2014.

In 2014, insurance plans will no longer be able to turn people away because of preexisting medical conditions. Nor will people with health conditions be charged higher premiums than healthy people. As a result, people in poor health who cannot work no longer have to fear being without access to coverage and care.

An estimated 24 million people will purchase coverage through new state-based health insurance exchanges. (In states that opt not to establish exchanges, the federal government will establish insurance exchanges instead.) Families with incomes between $30,000 and $88,000 a year will be eligible for premium subsidies for plans purchased through the exchanges. The subsidies would cap premium costs as a share of income at 3 percent for families earning
just over $30,000, rising with income to 9.5 percent for families earning $88,000. Out-of-pocket costs for direct medical expenses for families with incomes between about $22,000 and $55,000 would be reduced and ceilings established on maximum out-of-pocket expenses for families up to $88,000 in income.

The underinsured
The standard benefits package will help some 25 million working-age underinsured adults—those whose health care coverage does not protect them adequately from high medical expenses—and the 72 million adults overall who have difficulty paying their medical bills or medical debt. All plans sold to individuals through the insurance exchanges will have to cover all health services included in the standard benefits package. The package will help protect against high medical expenses, and federal premium subsidies will help ensure plan affordability for qualified families.

Individuals and families
For individuals and families, insurance will be easier to obtain and more affordable. Employer-sponsored insurance will remain the primary source of coverage for most families, covering about 56 percent to 60 percent of people under age 65 in 2019, roughly the same as now. The health insurance exchanges will offer choices of affordable plans with different levels of cost-sharing and premiums and a standard benefits package.

Small business and their workers
Currently, many small businesses cannot afford to offer health benefits. Those that do often must offer plans that have fewer benefits, charge higher premiums, and require higher levels of out-of-pocket spending. Consequently, people employed by small businesses often are uninsured or pay significantly more for coverage than those employed by larger businesses. Under reform, state insurance exchanges will ensure that individuals not covered by employers and small businesses with up to 50 to 100 employees will, at state discretion, have access to affordable coverage. The insurance exchanges will provide a stable source of affordable coverage for people who lose their jobs and their coverage. For small businesses that provide coverage, tax credits for two years will offset a portion of their costs.

Older adults
Older adults—those ages 50 to 64 and not yet eligible for Medicare—generally pay higher premiums in the individual market than younger people do, because they are considered higher risks. Similarly, insurance carriers charge higher premiums for small companies with older workforces. Premiums can vary by age by as much as 25 to 1 in the individual and small-group markets. Health reform places limits on insurers’ ability to raise premiums based on age. Premiums will not be allowed to vary by more than 3 to 1. For example, if a 20-year-old whose income is too high for a premium subsidy pays $2,637 a year for the premium of a silver plan offered through the exchange, a 60-year-old might pay as much as $7,911 a year without a subsidy, but no more.
Trend in the Number of Uninsured Nonelderly, 2013–2019
Before and After Health Reform

Millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Before reform</th>
<th>After reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>2014</td>
<td>51</td>
<td>26</td>
</tr>
<tr>
<td>2015</td>
<td>51</td>
<td>21</td>
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<td>2016</td>
<td>52</td>
<td>21</td>
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<tr>
<td>2017</td>
<td>53</td>
<td>22</td>
</tr>
<tr>
<td>2018</td>
<td>53</td>
<td>23</td>
</tr>
<tr>
<td>2019</td>
<td>54</td>
<td></td>
</tr>
</tbody>
</table>

Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 84% of legal nonelderly residents are projected to have insurance under the new law.

Source of Insurance Coverage Before and After Health Reform, 2019

Among 282 million people under age 65

Notes: Employees whose employers provide coverage through the exchange are shown as covered by their employers (5 million), thus about 29 million people would be enrolled through plans in the exchange. ESI is employer-sponsored insurance.
Seventy-Two Million Americans Have Problems with Medical Bills or Accrued Medical Debt, 2007

Percent of adults ages 19–64

<table>
<thead>
<tr>
<th>In the past 12 months:</th>
<th>2005</th>
<th>2007</th>
</tr>
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<tbody>
<tr>
<td>Had problems paying or unable to pay medical bills</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>39 million</td>
<td>48 million</td>
</tr>
<tr>
<td>Contacted by collection agency for unpaid medical bills</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>22 million</td>
<td>28 million</td>
</tr>
<tr>
<td>Had to change way of life to pay bills</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>24 million</td>
<td>32 million</td>
</tr>
<tr>
<td>Any of the above bill problems</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>48 million</td>
<td>59 million</td>
</tr>
<tr>
<td>Medical bills being paid off over time</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>37 million</td>
<td>49 million</td>
</tr>
<tr>
<td>Any bill problems or medical debt</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>58 million</td>
<td>72 million</td>
</tr>
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</table>


Medicare beneficiaries

All beneficiaries will continue to be guaranteed all of Medicare’s basic benefits. In fact, those benefits will be improved with expanded coverage for preventive care and reduced prescription drug costs. Preventive care will be free; beginning in 2011, beneficiaries will receive an annual wellness visit without a copayment. The Medicare Part D prescription drug coverage gap—informally known as the “doughnut hole”—will be phased out completely by 2020. Currently, the doughnut hole kicks in when beneficiaries exceed $2,830 in annual prescription drug claims, after which they must pay all drug costs until reaching $6,440, when Part D pays again. Increased assistance will be available to low-income beneficiaries.

Young adults

Young adults ages 19 to 25 constitute 19 percent of the uninsured. Among those without insurance, two-thirds report problems getting access to care and half report problems with medical bills or debt. Beginning in September 2010, young people will be allowed to remain under their parents’ coverage until age 26. Starting in 2014, Medicaid will be available to all adults with incomes at or below 133 percent of the federal poverty level. In addition, they will be able to buy coverage through insurance exchanges, where two-thirds of young adults (those with incomes below four times the poverty level) will receive help paying premiums and medical bills.

Children

Insurers will no longer be able to deny coverage to children with preexisting conditions. Reauthorization of the Children’s Health Insurance Program (CHIP) will be extended through 2015 and federal matching funds for states will be increased, helping states to expand coverage.
Growth in national health expenditures—currently $2.5 trillion annually—will slow, making premiums more affordable for employers and families, and easing fiscal pressures on government. Under reform, health care expenditures will grow an estimated 6 percent annually, compared with 6.6 percent as projected without reform. This may not seem like a big difference, but it is significant: In 2019, national health care expenditures are projected to be $4.5 trillion under reform, compared with an estimated $4.8 trillion without reform.

**Families and individuals**

Families and individuals purchasing coverage through insurance exchanges will have greater protection against out-of-pocket costs than currently available in the individual and small-group markets. According to a Commonwealth Fund analysis, reform will save the average American family $2,500 in 2019. The Medicare Hospital Insurance payroll tax will increase by 0.9 percentage points for individuals with incomes over $200,000, or couples with incomes over $250,000, to help pay for health reform, and such households will also pay a 3.8 percent tax on unearned income.

**Federal government**

Reforming health insurance will cost the government an estimated $820 billion over 10 years. However, reform has been designed so that it does not increase the federal deficit. In fact, between 2010 and 2019, health reform is expected to save $511 billion and to reduce the federal budget deficit by $143 billion. All expansions of coverage, improvements in services, and financial protection for low- and moderate-income families are financed by payment and system reform measures that slow the growth in total health expenditures and in Medicare, and by new tax revenues. Among the most significant cost offsets:

- Overpayments to Medicare managed care plans that benefit insurance companies and a minority of beneficiaries at the expense of all Medicare beneficiaries will gradually be eliminated. The Congressional Budget Office (CBO) estimates that phase-out of these overpayments will save $204 billion from 2010 to 2019.
Estimated Net 2010–2019 Payment and System Savings and Federal Budget Deficit Reduction After Reform

<table>
<thead>
<tr>
<th>Payment and System Savings</th>
<th>Federal Budget Deficit Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Reform</td>
<td>After Reform</td>
</tr>
<tr>
<td>-$511</td>
<td>-$143</td>
</tr>
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</table>


Dollars in billions

<table>
<thead>
<tr>
<th>Total Savings from Payment and System Reforms</th>
<th>CBO Estimate of Health Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Productivity improvement/provider payment updates</td>
<td>-$160</td>
</tr>
<tr>
<td>• Medicare Advantage reform</td>
<td>-$204</td>
</tr>
<tr>
<td>• Primary care, geographic adjustment</td>
<td>6</td>
</tr>
<tr>
<td>• Payment innovations</td>
<td>-$8</td>
</tr>
<tr>
<td>• Hospital readmissions</td>
<td>-$7</td>
</tr>
<tr>
<td>• Disproportionate share hospital adjustment</td>
<td>-$36</td>
</tr>
<tr>
<td>• Prescription drugs</td>
<td>29</td>
</tr>
<tr>
<td>• Home health</td>
<td>-$40</td>
</tr>
<tr>
<td>• Independent Payment Advisory Board</td>
<td>-$16</td>
</tr>
<tr>
<td>• Comparative effectiveness research and benefit design</td>
<td>—</td>
</tr>
<tr>
<td>• Other improvements and interactions</td>
<td>-$75</td>
</tr>
</tbody>
</table>

Medicare payments to providers will be adjusted for improvements in productivity. These adjustments will cover payments to inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. CBO projects savings of $160 billion through these adjustments from 2010 to 2019.

As the number of uninsured falls, Medicare and Medicaid’s disproportionate share payments to hospitals will decrease to reflect lower uncompensated care costs. CBO estimates savings of $36 billion over 10 years from these adjustments.

The increase in the Medicare Hospital Insurance tax paid by high-income earners will raise an estimated $210 billion over 2012–2019.

New annual fees paid by insurers will yield an estimated $60.1 billion over 2014–2019.

New annual fees on pharmaceutical manufacturers will raise an estimated total of $27 billion over 2011–2019.

A 2.9 percent excise tax on medical device manufacturers will yield an expected $20 billion over 2013–2019.

An excise tax on high-cost insurance plans will raise an estimated $32 billion over 2018–2019.

Under reform, Medicare spending growth will be slowed from projected increases of 6.6 percent to 5.2 percent. In this way, health reform will extend the solvency of the Medicare trust fund through 2026 and save $397 billion from 2010 to 2019.

While the projected 69 percent growth under reform will be significantly lower than projected prior to reform—89 percent—even this reduction is greater than projected growth in the rest of the U.S. economy: The Gross Domestic Product (GDP) will increase an estimated 63 percent between 2009 and 2019.

Business

Businesses of all sizes stand to gain under reform, though costs will increase initially for employers that do not currently shoulder some responsibility for providing coverage. Rises in premiums will slow, yielding substantial savings to employers over time.

In addition, tax credits and subsidies will be available for small businesses that contribute to their employees’ premiums. For firms with 10 employees or fewer and average wages below $25,000 that contribute 50 percent of their employees’ premiums, the new law will provide tax credits for up to two years. These credits will be phased out for firms with up to 25 employees and average wages...
Four Benefit Categories Under Essential Benefits Package

- **Bronze**: Covers 60% of enrollees’ medical costs, with out-of-pocket spending limited to what is defined for health savings accounts (HSAs) or $5,950 for individual policies and $11,900 for family policies.
- **Silver**: Covers 70% of medical costs with same out-of-pocket limits.
- **Gold**: Covers 80% of medical costs with same out-of-pocket limits.
- **Platinum**: Covers 90% of medical costs with same-out-of-pocket limits.

All benefit categories will have the essential benefits package. Policies may be sold in small-group and individual markets or exchanges that do not meet actuarial standards for the benefit categories established by law. All carriers selling in the individual and small-group markets are required to offer at least the silver and gold plans.

For example, instead of paying providers according to the current fee-for-service model, Medicare and other payers may pay according to how well providers manage the care and health of their patients with chronic illnesses, like diabetes. Or they may start “bundling” payments for hospital procedures—instead of separate payments to hospitals and doctors involved in a patient’s care, a single reimbursement would cover an entire hospital stay for a medical procedure.

Under these payment approaches, providers demonstrating superior patient outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative, or avoidable services may not fare as well, and might strive to improve their care.
Despite significant advances under reform, the U.S. health system is unlikely to reach its potential without more far-reaching measures in the coming years. Most important, an estimated 15 million legal residents will remain uninsured—including many exempt from the requirement to carry coverage because of their incomes. Subsidies for low-income families and small firms may need to be expanded to cover the remaining uninsured. And while Medicare will explore payment reforms to make health care more effective and more efficient, private sector payers will need to change their payment methods too.

There are also very real, immediate challenges related to implementation of current reforms. For example:

- What will happen to people who lose their jobs between now and 2014, when expanded coverage begins? The final reform law does nothing to extend government-mandated COBRA benefits, which currently expire after 18 months.
- How will the nation’s safety net of public hospitals and community clinics be sustained and restructured under health reform?
- What else needs to be done to ensure a strong primary care system that prevents acute illness, manages chronic illness, and coordinates care among providers?
- What are the states’ capacities for implementing reform? How many will establish new insurance exchanges and expand their Medicaid programs?
Conclusion

Health reform will fundamentally alter our present course of rising costs and increasing numbers of uninsured and underinsured. The new law represents a pragmatic approach to closing gaps in insurance coverage, building on a mix of employer coverage and private plans in health insurance exchanges, retention of Medicare, and expansion of Medicaid. It will lay the foundation for a high performance health system affording access to care for all, improved quality, and greater efficiency.

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