Health care reform cannot wait, it must not wait, and it will not wait another year.

President Obama, February 24, 2009

“Rule one: Never allow a crisis to go to waste. They are opportunities to do big things.”

Rahm Emanuel, Obama Chief of Staff

On 23 March 2010, Congress passed the Patient Protection & Affordable Care Act.

Setting the Stage:
Three Key Facts Regarding US Health Care

- Significant gaps and inequities in population access to health insurance.
  - The US was the only developed country without a national policy regarding health insurance coverage.

- The US spends more on health care than other developed countries.

- Health care expenditures are rising and continuing to grow.
  - Rising health expenditures are the most critical factor affecting the long-term fiscal health of the U.S.
  - Recent evidence suggests a decline in the growth of per capita health spending.
  - However, spending growth still exceeds that of GDP.
Setting the Stage: Some Other Issues

• We are still feeling aftershocks of the Great Recession (12/07 – 6/09).
  – Sluggish economic growth & high unemployment.
  – Slight decline in GDP during Q4 2012.
  – Losses of employment and health insurance, validating the need for strong social safety net.
  – Serious implications for state tax revenues.

• Sequestration:
  – Refusal of House Republicans to raise debt ceiling in 2011 without significant deficit reduction.
  – Two parties agreed to the Budget Control Act
    • Cut domestic spending by $1 trillion over ten years.
    • Democrats offered further cuts without additional tax revenues but Republicans refused.
    • Congress set up new committee.
      • To find an agreement; bicameral mechanism established with cuts so onerous that would never happen.
      • Since no agreement reached, cuts took effect March 1, 2013.
      • $110 billion per year cut from non-defense discretionary spending & defense spending for 2013 – 2022.
      • Sequestration cuts will affect CDC, cancer screenings for low-income women, community health centers, food safety workers among others damaging effects to health & safety.

Setting the Stage: Some Other Issues

• Growing income inequality:
  – Between 1979 & 2007, for the top 1% of the population with the highest incomes, real after-tax household income grew by 275%.
    • Presently, the top 1% of households holds roughly 24% of the nation’s income.
  – For those in the 81st through 99th percentiles, average real after-tax household income grew by 65 percent over that period.
  – For those in the 60 percent of the population in the middle of the income scale (the 21st through 80th percentiles), the growth in average real after-tax household income was just under 40 percent.
  – For the 20 percent of the population with the lowest income, average real after-tax household income was about 18 percent higher in 2007 than it had been in 1979.
  – Most recent data show that post-recession, top 1% of earners had a 11.2% increase in income in 2009 compared to only a 0.4% increase for bottom 99%.

Outline of Talk

• Why Health Care Reform?
• How Radical is the Affordable Care Act?
• Some Key Provisions of the ACA
• The ACA: An Update:
  – Recent Developments, Ongoing Concerns, & Early Findings
• Ongoing Challenges Facing the ACA
• Summing Up
Why Health Care Reform?

The Crisis in Health Care Spending

• Rising spending for health care pose a serious threat to the future fiscal condition of the U.S.
  – Inflation-adjusted national health expenditures have increased from $150.1 billion in 1960 to 2.5 trillion in 2009.
  – Annual growth rate of 5.7% per annum.
  – Inflation-adjusted per capita health spending has increased from $796 in 1960 to $7,375 in 2009.
  – Annual rate of 4.7%.
  – For past 30 years, rise in health care spending > rise in GDP by 2.8% per annum.
  – If trend continues for another 30 years, health care spending will absorb 36% of GDP.
  – Health care spending alone represents 19% of the federal budget.
  – Medicare & federal share of Medicaid projected to be 6% in 2019, and 12% by 2050.

• Peter Orszag, former OMB Director: "The nation’s long-term fiscal balance will be determined primarily by the future rate of health care cost growth."

Two Striking Features of US Health Care Spending

• In 2010, the US spent $2.7 trillion on health care alone.
  – Stacking $1 bills, this represents 2/3rds of the distance to the moon.

• The US health care sector represents the fifth largest economy in the world.
  – e.g., Exceeds the GDP of France & United Kingdom.
Relative Contributions of Different Types of Health Services to Total Growth in National Health Expenditures, 1999-2009

Notes: Percentages may not total 100% due to rounding. Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.


Health Spending per Capita, 2009
Adjusted for Differences in Cost of Living

<table>
<thead>
<tr>
<th>Country</th>
<th>Dollars</th>
<th>% GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ</td>
<td>$2,992</td>
<td>10.2%</td>
</tr>
<tr>
<td>AUS</td>
<td>$3,465</td>
<td>12.1%</td>
</tr>
<tr>
<td>UK</td>
<td>$3,722</td>
<td>12.8%</td>
</tr>
<tr>
<td>SWE</td>
<td>$3,978</td>
<td>13.8%</td>
</tr>
<tr>
<td>FRA</td>
<td>$4,218</td>
<td>14.6%</td>
</tr>
<tr>
<td>GER</td>
<td>$4,363</td>
<td>15.1%</td>
</tr>
<tr>
<td>CAN</td>
<td>$4,914</td>
<td>16.2%</td>
</tr>
<tr>
<td>NZL</td>
<td>$5,144</td>
<td>16.4%</td>
</tr>
<tr>
<td>GBR</td>
<td>$5,352</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

Source: OECD Health Data 2011 (June 2011).

National Health Expenditures and Their Share of Gross Domestic Product, 1960-2008

Dollars in Billions:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHE</td>
<td>53</td>
<td>57</td>
<td>63</td>
<td>71</td>
<td>77</td>
<td>83</td>
<td>90</td>
<td>98</td>
<td>106</td>
<td>113</td>
<td>120</td>
<td>127</td>
<td>134</td>
<td>142</td>
<td>150</td>
<td>158</td>
<td>166</td>
<td>174</td>
<td>182</td>
<td>190</td>
<td>198</td>
</tr>
<tr>
<td>GDP</td>
<td>725</td>
<td>747</td>
<td>770</td>
<td>802</td>
<td>835</td>
<td>867</td>
<td>900</td>
<td>933</td>
<td>966</td>
<td>999</td>
<td>1032</td>
<td>1065</td>
<td>1100</td>
<td>1135</td>
<td>1170</td>
<td>1205</td>
<td>1240</td>
<td>1275</td>
<td>1310</td>
<td>1345</td>
<td>1380</td>
</tr>
</tbody>
</table>


NHE as a Share of GDP:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of GDP</td>
<td>7.2%</td>
<td>7.2%</td>
<td>7.2%</td>
<td>7.3%</td>
<td>7.3%</td>
<td>7.4%</td>
<td>7.5%</td>
<td>7.6%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.8%</td>
<td>7.9%</td>
<td>8.0%</td>
<td>8.1%</td>
<td>8.2%</td>
<td>8.3%</td>
<td>8.4%</td>
<td>8.5%</td>
<td>8.6%</td>
<td>8.7%</td>
<td>8.8%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

(continued on next page)
Medicare Spending as a Share of Total Federal Outlays, FY 2011

FY 2011 Total Federal Outlays = $3.6 trillion

NOTE: FY is fiscal year. Expenses for Medicare include spending and exclude offsetting premium receipts, premiums paid by beneficiaries and state contributions.
Health Care Costs Concentrated in Sick Few—
Sickest 10 Percent Account for 65 Percent of Expenses

Distribution of health expenditures for the U.S. population,
by magnitude of expenditure, 2009

Sources of Health Care Spending

- Aging of the population.
- Our income/wealth position.
- Prices and payments to providers.
- Prescription drug prices.
- **Medical Technology**.
- Dominant role of third-party payers.
- Costs of administering multiple payment system.
- Geographic differences in practice patterns.
- Medical errors & lack of information technologies.

*However, should not lose cite of benefits side:*
- *What’s the payoff U.S. medical spending?*

Estimated Contributions of Selected Factors to Real Health Spending per Capita, 1940-1990 (CBO, January 2008)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging of population</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Changes in third-party payments</td>
<td>10</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Personal income growth</td>
<td>11-18</td>
<td>5</td>
<td>&lt;23</td>
</tr>
<tr>
<td>Prices in health care sector</td>
<td>11-22</td>
<td>19</td>
<td>Not estimated</td>
</tr>
<tr>
<td>Administrative costs</td>
<td>3-10</td>
<td>13</td>
<td>Not estimated</td>
</tr>
<tr>
<td>Defensive medicine &amp; supplier-induced demand</td>
<td>0</td>
<td>Not estimated</td>
<td>0</td>
</tr>
<tr>
<td>Technology changes</td>
<td>38-62</td>
<td>49</td>
<td>&gt;65</td>
</tr>
</tbody>
</table>
Exhibit 8. Volume of Knee and Hip Replacements, 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Knee Replacements</th>
<th>Hip Replacements</th>
</tr>
</thead>
<tbody>
<tr>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUS*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAN*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NETH*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOR*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: OECD Health Data 2011 (Nov. 2011).

Exhibit 9. Diagnostic Imaging in Select OECD Countries

<table>
<thead>
<tr>
<th>Devices per million pop., 2009</th>
<th>Exams per 1,000 pop., 2009</th>
<th>MRI scan fees, 2011</th>
<th>CT scan (head) fees, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Median per country | | | |

Source: OECD Health Data 2011 (Nov. 2011).

Differences in Spending at a Point in Time: U.S. vs. Canada

<table>
<thead>
<tr>
<th>Source: Pozen &amp; Cutler (2010)</th>
<th>$ per capita</th>
<th>% of total difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total difference</td>
<td>$1,589</td>
<td>—</td>
</tr>
<tr>
<td>Provider incomes</td>
<td>$490</td>
<td>31%</td>
</tr>
<tr>
<td>Additional procedures for hospital patients</td>
<td>$224</td>
<td>14%</td>
</tr>
<tr>
<td>Administration</td>
<td>$619</td>
<td>39%</td>
</tr>
<tr>
<td>Total accounted for</td>
<td>$1330</td>
<td>84%</td>
</tr>
</tbody>
</table>

More on Administrative Cost Differences

<table>
<thead>
<tr>
<th>U.S.</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative workers/office-based physician</td>
<td>2.2</td>
</tr>
<tr>
<td>Administrative workers/hospital bed</td>
<td>1.5</td>
</tr>
<tr>
<td>Health insurance administration as % of premiums</td>
<td>12%</td>
</tr>
</tbody>
</table>

Also: U.S has 25% more health care administrators than the UK, 165% more than the Netherlands, & 215% more than Germany.
Why is there Concern over US Health Care Expenditures?

- Do health care choices reflect preferences of well-informed consumers?
- Trust and agency relationships – Are physicians disinterested agents?
  - Would providers make the same choices as a well-informed consumer?
- Separation between consumption and payment.
  - Role of moral hazard
- Resource allocation issues – opportunity cost and distribution.
- Financing issues – health care expenditures growing faster than tax revenues and wages.
  - Issue of affordability.
- Payoff to health expenditures.

Observation by Uwe Reinhardt

- Given that half of all health spending is now tax financed and flows through public budgets, and given the refusal of American voters to see taxes increased, these trends will inevitably squeeze spending on other social priorities, including education, support of science, and, of course, a variety of programs to assist low income Americans.

  - The trimming of these other, non-health spending programs is underway as we speak.

An Important Postscript

- Since 2001, the annual rate of growth in care spending has attenuated although still > growth in GDP.
  - Spending growth has declined consistently since the early part of this century:
    - From a high of 9.6% growth between 2001 & 2002 to a growth of 3.9% between 2009 & 2010.
    - Recent growth of health spending just 0.8% higher than GDP.
      - Between 1985 – 1998, 3.2% higher.
- Factors responsible for decline in annual growth rates:
  - Shifts to value-based purchasing
  - Expiration of patents for “blockbuster” drugs.
  - Continued use of generic drugs.
  - Reductions in provider payment rates by Medicare & Medicaid.
  - Development of integrated care delivery systems.
Why Health Care Reform?

The Crisis in Health Care Coverage

Trends in the Number of Nonelderly Americans without Health Insurance

Trends in the Percent of Nonelderly Americans without Health Insurance
NOTES: Data may not total 100% due to rounding. The Federal Poverty Level for a family of four in 2011 was $22,350 (according to the HHS poverty guidelines).

SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.
Impact of the Rise in Unemployment on Health Coverage, 2008 to 2009

- Decrease in Employer Sponsored Insurance (million)
- Medicaid / CHIP Enrollment Increase (million)
- Uninsured Increase (million)

National Unemployment Rate Increase since 2008 (from 7.2% in Dec-08 to 10.0% in Nov-09)

= 2.8
3.0
6.9

Note: Totals may not sum due to rounding and other coverage.

Source: Based on John Holahan and Bowen Garrett, Rising Unemployment, Medicaid, and the Uninsured, prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2009.

Medicaid Enrollment Increased by Nearly 6 Million During the Great Recession

Monthly Enrollment in Millions

<table>
<thead>
<tr>
<th>Dec-03</th>
<th>Dec-04</th>
<th>Dec-05</th>
<th>Dec-06</th>
<th>Dec-07</th>
<th>Dec-08</th>
<th>Dec-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.4</td>
<td>41.9</td>
<td>42.6</td>
<td>42.3</td>
<td>42.8</td>
<td>44.8</td>
<td>48.5</td>
</tr>
</tbody>
</table>

Source: Analysis for KCMU by Health Management Associates, using compiled state Medicaid enrollment reports.

Why are Some People Uninsured?

- Actuarial unfairness
  - Administrative costs.
  - Pricing irregularities.
  - Adverse selection.
- Imperfections in health insurance markets:
  - Competition on basis of risk selection.
    - Insurers have strong incentives to favorably select enrollees.
  - Value of insurance & preferences:
    - Affordability & liquidity constraints.
    - Unavailability of specific benefits.
    - Risk preferences.
  - Availability of uncompensated care.
- Human capital deficits preclude access to jobs offering coverage.
- Changing nature of the employment contract.
- Stigma and "trust" regarding public programs.
  - Need for aggressive outreach.
- Key distinction:
  - Insurance typically for the healthy, not the sick; The sick need health services.
  - Social versus private insurance.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers’ earnings have been updated to reflect new industry classifications (NAICS).


Percentage Increase in Health Insurance Premiums Compared to Inflation

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2012

Increases in Health Insurance Premiums Compared with Other Indicators, 1998–2007

*Estimate is statistically different from the previous year shown at p<0.05. ^Estimate is statistically different from the previous year shown at p<0.1.
Average Annual Premiums for Single and Family Coverage, 1999-2012


Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2012

Note: These estimates include workers enrolled in HSA/HRO and other plans. Because we do not collect information on the attributes of conventional plans, it is reasonable, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because HSA/HRO plans are generally not offered to a large number of workers, the impact of this assumption on the results is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.


Percentage of All Firms Offering Health Benefits, 1999-2012

Note: Estimates are statistically different from estimate for the previous year shown (p<.05).

Why Health Reform?

Are We Getting Value for Money?
HEALTHY LIVES

Infant Mortality Rate

Potential Years of Life Lost per 100,000 Persons, 2004

Overall Ranking

OVERALL RANKING

Country Rankings

UK

US

Canada

Germany

Japan

Quality Care

Effective Care

Safe Care

Coordinated Care

Patient-Centered Care

Access

Cost-Related Problem

Timeliness of Care

Efficiency

Equity

Long, Healthy, Productive Lives

Health Expenditures/Capita, 2007 ($)

AUS

CAN

GER

NETH

NZ

Overall Ranking

1.00–2.33

2.34–4.66

4.67–7.00

AUS

CAN

GER

NETH

NZ

UK

US

3

5

7

5

3

1

6.5

1

2

6

3,357

3,895

3,588

3,837

2,454

2,992

7,290
Medical, Medication, or Lab Test Errors in Past Two Years

<table>
<thead>
<tr>
<th>Percent</th>
<th>AUS</th>
<th>CAN</th>
<th>FR</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong medication or dose</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>13</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Medical mistake in treatment</td>
<td>17</td>
<td>16</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>15</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Incorrect diagnostic/lab test results*</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Delays in abnormal test results*</td>
<td>13</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Any medical, medication, or lab errors among those w/ tests</td>
<td>29</td>
<td>29</td>
<td>18</td>
<td>19</td>
<td>17</td>
<td>25</td>
<td>20</td>
<td>34</td>
</tr>
</tbody>
</table>

Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.

Medical Care is Just One Factor Associated with ‘Good Health’

- Genetic endowment
- Behavior and attitudes
- Socioeconomic status
  - Income
  - Education
  - Occupation status
- Physical and social environment
- Time allocated to the production of health
  - Exercise
  - Nutrition

Why Health Reform?

Assuring Health Security
Figure 4: Among Adults with Employer-Sponsored Coverage in January 2006, Percent Uninsured in Each Month by Family Income, January 2006 to December 2007

Note: Family income is based on income in 2006.

Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2012

Note: Tests found no statistical difference from estimate for the previous year shown (p<.05). No statistical tests are conducted for years prior to 1999.

Percentage of Americans with High Financial Burden from Health Care Spending, 2001–2006

2010: 29 Million Adults Under Age 65 Underinsured, 81 Million Either Underinsured or Uninsured

Uninsured during year: 45.5 million (36%)

Insured, not underinsured: 110.9 million (85%)

Uninsured during year: 32 million (26%)

Insured, not underinsured: 132 million (88%)

2003
Adults 19-64 (172 million)

Uninsured during year: 15.6 million (9%)

Insured, not underinsured: 110.9 million (65%)

Underinsured*: 29 million (16%)

2010
Adults 19-64 (184 million)

Uninsured during year: 45.5 million (26%)

Insured, not underinsured: 110.9 million (65%)

Underinsured*: 28 million (16%)

* Underinsured defined as insured all year but experienced one of the following: medical expenses equal to 10% or more of income; medical expenses equal to 5% or more of income if low income (<200% of poverty); or deductibles equal to 5% or more of income.


Prevalence of High Out-of-Pocket Burdens Among the Non-Elderly, By Income Level and Insurance Status, 2001 vs. 2006

Percent with Total Out-of-Pocket Burden >10% of Income

<table>
<thead>
<tr>
<th>Income Level</th>
<th>2001</th>
<th>2006</th>
<th>Statistically Significant Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100-199% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200-399% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>400%+ FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Total financial burden includes all out-of-pocket payments for health care, including premiums. Family income is measured using before-tax income. Health insurance includes private-group and nongroup insurance.


Financial Consequences of Medical Bills

Percent who say they have experienced each of the following in the past 5 years because of medical bills...

- Been contacted by a collection agency: 20%
- Had difficulty paying other bills: 20%
- Used up all or most of savings: 17%
- Been unable to pay for basic necessities: 12%
- Borrowed money or gotten a loan or a 2nd mortgage: 16%
- Declared bankruptcy: 1%
- Had any of the above problems: 35%

Source: Kaiser Family Foundation Health Tracking Poll: Election 2008 (conducted Apr 3-13, 2008).
Why Health Care Reform?
Other Concerns

- Significant concerns over equity and efficiency in current health care system.
- Concerns over insurer practices and value of policies:
  - Recission of enrollees from health plans.
  - Use of pre-existing condition exclusions.
  - Erosion of plan protection.
  - Constraints on annual & lifetime plan payments.
- Disparities in health care access and outcomes by race, ethnicity, and SES.

How Radical is National Health Reform?

National Health Reform:
Fundamental Changes

- The Patient Protection & Affordable Care Act was signed into law by President Obama on March 23rd.
- Underlying the law are fundamental shifts in how we view health care & health insurance:
  - Validates health care as a right as part of the social contract but also an obligation.
  - Integrates social insurance principles into a private health insurance system.
National Health Reform: Fundamental Shifts

- Emphasis on consumer protection:
  - "Value for money" in health insurance.
  - Minimum standards of coverage.
  - True catastrophic protection.
  - Eliminate rescinding enrollment for those who become ill.

- Raises issues of state regulation of insurance established in McCarrin-Ferguson Act.

- Chips away at ERISA pre-emption of state insurance regulation.

"... the new health reform law is anything but radical" (J. Oberlander & T. Marmor (NY Review of Books, August 19, 2010).

- Does not replace existing U.S. health insurance schemes with a single payer.
  - Maintains employment-based insurance, individual insurance market, Medicaid, & Medicare.
  - Does not alter our dependence on private, for-profit health insurance plans.
- Imposes no effective controls on premiums.
  - Risk adjustment according to age, location, family composition & tobacco use.
  - Maximum premium variation by age: 3:1.
- Builds on health reform previously established in Massachusetts.
- Builds on state insurance market reforms & public insurance expansions.
- Builds on state expansions of young adult dependent coverage.
- Builds on state provisions of high risk pools.
- Does not change how medical care is organized, paid for, and delivered.
  - Absence of reliable, system-wide controls on medical costs.
  - Absence of budgetary targets for spending & tight regulation of provider payments (except for Medicare).
  - E.g., will largely retain fee-for-service payment for physicians.
- Considers cost-containment strategies that have been widely discussed.

The ACA Builds on Massachusetts Health Reform: The Individual Mandate

- Governor Mitt Romney (2006):
  - "Some of my libertarian friends balk at what looks like an individual mandate. But remember, someone has to pay for the health care that must, by law, be provided: Either the individual pays or the taxpayers pay. A free ride on the government is not libertarian."

Wall Street Journal 4/11/06
The ACA Builds on Health Reform in Massachusetts

- **Key elements of Massachusetts reform:**
  - Existing insurance arrangements maintained.
  - Increased eligibility for Medicaid to 300% of FPL.
    - Individual & "pay or play" employer mandate.
      - Exemption for those unable to "afford" coverage and for employers with 10 or fewer employees.
      - Penalty of $295 per employee for eligible employers who do not offer coverage.
    - Merger of individual & small group markets.
      - Guaranteed issue of health plans required.
      - Modified community rating by age (2:1 rate band between young and old).
    - Commonwealth Health Connector.
      - Clearinghouse for those purchasing private insurance.
      - Specifies health benefits & prices for plans inside/outside connector.
    - Commonwealth Care Subsidy Program.
      - Subsidies for individuals with incomes between 100% & 300% of FPL.

The ACA Builds on Health Reform in Massachusetts

- **Results to date:**
  - Uninsured rate reduced by more than half.
  - High compliance rate.
  - Successful market reform for those with incomes > 300% of FPL.
    - Non-group premiums reduced to half their prior levels.
    - Slower premium growth through connector.
  - Some issues:
    - Availability of physicians (supply side) in rural parts of state.
    - Enforcement & preferences for coverage.
    - Cost increases & weak economy.

- **However, unique circumstances in MA:**
  - Low uninsured rate (9%) in 2006.
  - Permission to use $4 million transfer from Section 115 waiver for insurance subsidies.
  - MA uncompensated care pool in place to provide some of funding.

Key Provisions of the ACA
Key Elements of Reform: 2010 Implementation

- **Private insurance reform:**
  - Pre-existing conditions:
    - Eliminated for children by September 2010.
    - For all others in 2014.
  - Cannot rescind coverage due to illness.
  - No lifetime limits on the dollar value of coverage.
  - High risk pool within 90 days until 2014: Enrollment suspended due to solvency issues.
  - Loss ratios of 80% in small group & individual market; 85% in large group market.
  - Coverage for non-dependent children up to age 26.
  - Requires qualified health plans to eliminate cost-sharing for services rate A or B by US Preventive Services Task Force.
  - Tax credits to employers w/ < 26 workers & average wages < $50K.
  - Temporary reinsurance program for employers providing retiree coverage to those over age 55 not eligible for Medicare.

Key Elements of Reform: 2010 Implementation

- **Private Insurance (continued):**
  - Establish process for reviewing increases in health plan premiums.
  - States to review trends in premiums and recommend whether plans should be excluded from health insurance exchanges.

- **Medicare:**
  - $250 rebate to Part D beneficiaries who reach “doughnut hole”.
  - Doughnut hole to be phased out by 2020.

- **Medicaid:**
  - State option to cover childless adults.
  - State option to cover family planning to certain low-income persons.

- **Quality Improvement**
  - Establish non-profit Patient Centered Outcomes Research Institute within CMS

- **Workforce:**
  - Increase supply through scholarships and loans.

Key Elements of Reform: 2011 Implementation

- **Long-term Care:** **RESCINDED**
  - Voluntary insurance program for community living assistance services & support (CLASS)

- **Medical Malpractice:**
  - Five-year demonstration programs for alternative tort litigations.

- **Prevention / Wellness:**
  - Eliminate Medicare cost-sharing for A&B preventive services.
  - Waive Medicare deductible for colorectal cancer screening.
  - Grants to small employers for wellness programs.
  - Require chain restaurants & vending machines to disclose nutritional content.
Key Elements of Reform: 2011 Implementation

- Medicare:
  - 50% discounts on brand-name drugs filled under Part D.
  - 10% Medicare bonus to primary care MDs and surgeons practicing in shortage areas.
  - Create innovation center with CMS.

- Quality Improvement:
  - Develop national quality improvement strategy.
  - Establish network program to coordinate/integrate care to low-income, uninsured, & underinsured populations.
  - Increase funding by $11 billion for community health centers & National Health Service Corps.

- Medicaid:
  - Prohibit federal payments for health care acquired conditions.
  - In 2012: Demonstration projects to pay bundled payments for episodes of care that include hospitalizations.

Key Elements of Reform: 2014 Implementation

- Individual mandate: Require all US citizens and legal residents to have coverage.
  - Exemptions based on financial hardship / religious objections / etc.
  - Subsidies to assist purchase of health insurance.
  - Penalties for non-compliance to be phased in.
    - The greater of $695 annually up to a maximum of 3X that amount ($2085 per family) or 2.5% of family income.

- State-Based American Health Benefits Exchanges & Small Business Health Options Program Exchanges
  - State or regional-based exchanges.
    - Four benefit tiers & option for Basic Health Plan for the uninsured (133% - 200% FPL).
    - Open to those without “qualifying coverage” (the uninsured, those not offered coverage, those underinsured).
    - Open to employers with up to 100 employees.
    - States can decide to add employers with > 100 workers in 2017.

Key Elements of Reform: 2014 Implementation (continued):

- Health Insurance Exchanges (continued):
  - Require guaranteed issue & renewal, & prohibitions on pre-existing condition exclusions.
    - Also applies to individual & small group markets.
  - Premium variation based on age (3:1 ratio), location, family composition, & tobacco use (1.5:1 ratio).
    - Also applies to individual & small group markets.
  - Provide refundable & advanceable premium credits & cost sharing subsidies to individuals & families with incomes 133% - 400% FPL.
    - However, employee premium contributions cannot exceed 9.5% of income.
  - Cost-sharing subsidies to individuals & families 100% to 400%FPL.
  - Require qualified health plans to offer an essential health benefits package.
    - Also applies to plans in individual & small group markets.

- Outside the exchange:
  - Prohibit individual & group health plans from placing annual limits on dollar value of coverage.
### Key Elements of Reform: 2014 Implementation

**Health Insurance Exchanges (continued):**

- No public plan but federal OPM would contract with insurers to offer at least two multi-state plans in each exchange.

- Separate catastrophic plan for those up to age 30 or exempt from mandate (effective in 2015).

- Reduce out-of-pocket limits for those with incomes < 400% FPL.
  - Applied within actuarial limits of plan / will not increase actuarial value.

### Key Elements of Reform: 2014 Implementation

**Private Insurance:**

- All non-grandfathered individual & small group health insurance plans sold in a state (and HIEs) to offer certain essential health benefits.

- Employer requirements:
  - Penalties for employers >= 50 workers if:
    - Don’t offer coverage and have at least one full-time employee receives a premium tax credit ($2000 penalty per full time worker w/ first 30 workers exempt).
    - Offer coverage and have at least one full-time employee receive a premium tax credit ($2000 penalty per full time worker w/ first 30 workers exempt or $3000 per worker, whichever is less).
    - Exempt firms with < 50 employees from penalties.

  - Subsidies to small employers with 25 or fewer employees & annual average wages of < $25,000. Up to 35% of employer contribution, 2010 – 2013.
  - Tax credits of up to 50% to small businesses purchasing coverage through the exchanges.

### Key Elements of Reform: 2014 Implementation

**Medicaid:**

- Expanded to all eligible non-Medicare individuals with incomes < 138% FPL.
  - Guarantee benchmark benefit package meeting essential health benefits available through health insurance exchanges.
A Key Concern of Implementation: Can I Keep My Coverage?

- The ACA "grandfathers" health plans that were in effect March 23, 2010.
  - Employers & insurers must elect to have existing plans grandfathered & can continue to offer plan after 2014.
  - Grandfathered plans must comply with some provisions:
    - No lifetime limits on coverage.
    - No waiting period > 90 days.
    - Comply with new loss ratios.
    - Cover dependent children to age 26.
  - Grandfathered plans exempt from:
    - Cover minimum package of essential health benefits.
    - Limits on cost sharing.
    - Capped deductibles ($2000 for single coverage & $4000 for family coverage).
    - Coverage of preventive services without cost sharing.
    - Limits on tail-adjustment of premiums.
  - Grandfathered plans limited in making changes:
    - Can’t eliminate essential benefits for specific conditions.
    - No increases in coinsurance.
    - Limits on increase in deductibles & fixed dollar co-payments.
    - Employer contributions cannot decrease by > 5%.
    - Employers cannot change carriers.

- The "grandfather" provision represents a tradeoff for employers:
  - Can provide existing coverage but limits on short-term cost containment measures.

Key Elements of Reform: Beyond 2014

- Close Medicare Rx doughnut hole by 2020.
- Tax "Cadillac" health plans beginning in 2018:
  - 40% excise tax on insurers for plans > $10,200 for individuals & $27,500 for families.
- Medicare tax on investment income for individuals with incomes >$200K & couples > $250K.
- Annual fees on health care companies: medical devices, drug companies, insurance companies.
- Cut payments to Medicare Advantage plans.
- Set limit on contributions to flexible spending accounts.
- Increase threshold for medical expense deductions (10% AGI up from 7.5%).
- Medicaid expansion with federal government assisting states
  - Federal government pays 100% of costs between 2014 & 2016; 90% starting in 2020.

Cost Containment Provisions

- Administrative health insurance simplification:
  - Single set of rules for eligibility verification, claims status, funds transfer, payment & remittance, claims information, etc.
- Medicare:
  - Restructure payments to Medicare Advantage plans.
  - Establish Independent Payment Advisory Board
    - Submit proposals to reduce per capita growth in spending.
    - Reduce DSH payments initially by 75%.
    - Raise later on based on % population uninsured & amount of uncompensated care provided.
  - Create Innovation Center with CMS to evaluate different payment structures to reduce spending & improve quality.
  - Allow ACOs meeting quality standards to share in cost savings.
  - Reduce payments to hospitals for with excess of preventable readmissions.
- Medicaid:
  - Increase Medicaid drug rebate.
  - Reduce aggregate DSH payments to states.
  - Prohibit federal payments for health care acquired conditions.
Cost Containment Provisions

• Create Innovation Center with CMS to evaluate different payment structures & improve quality.
• Reduce waste, fraud, & abuse in public programs.
• Electronic medical records & information technology.
• Demonstration programs:
  – Medicaid to pay bundled payments for episodes of care with hospitalizations.
  – Award five-year grants to states to develop, implement, & evaluate alternatives to current tort litigation.

Cost Containment: Accountable Care Organizations

• ACOs: networks of doctors and hospitals sharing responsibility for the health of their patients.
  – Seamless sharing of information.
  – Achievement of quality targets.
• ACO agrees to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.
• ACOs face financial incentives to cooperate and save money by avoiding unnecessary tests and procedures & meeting quality targets.
• Types of payment systems:
  – Shared savings: FFS payment but ACOs share in savings if lower spending (not at risk to lose money).
  – Shared savings & shared losses: FFS payment by ACO responsible for paying back losses if spending does not decline.
  – Full capitation payment: fixed monthly payment per patient – ACO responsible for any loss and captures any savings.
  – Partial capitation payment: combination of FFS and fixed per patient payment.
  – Pioneer ACOs – well-established provider groups whose payment system will vary over time from shared savings to full responsibility.
• CMS has approved 3 ACOs for NJ: Atlantic Health Systems; Hackensack Physician-Hospital Alliance; & Optimus Health Care Partners

Financing

• Fees imposed on the pharmaceutical and health insurance sectors.
• Reduce spending on Medicare by $500 billion over next decade.
• Increase (by 0.9%) Medicare part A payroll tax for individuals (> $200K) & families (> $250K).
• Tax on “Cadillac” health plans.
• Raise threshold for deducting unreimbursed medical expenses from 7.5% to 10% of AGI.
• Other charges and payment changes.
Projected Economic Impact of Reform

- Cost at $940 billion over next decade.
- Reduce federal deficit by $138 billion over next decade.
- Reduce uninsured by 32 million when fully implemented in 2019.
  - However, will leave 22 million uninsured.

Medicare Spending with System Savings, 2010–19:
Before and After Reform

![Graph showing Medicare Spending with System Savings, 2010–19: Before and After Reform]

Payment and System Reform Savings from ACA
Provisions, 2010–19

<table>
<thead>
<tr>
<th>Savings in billions</th>
<th>CBO estimate of Affordable Care Act of 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Savings from Payment and System Reforms</td>
<td>-$511</td>
</tr>
<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>Other improvements and interactions</td>
<td>-75</td>
</tr>
</tbody>
</table>

Recent Developments, Ongoing Concerns, & Early Results

The Constitutional Challenge to Health Reform: The Individual Mandate

• Prior to summer 2012:
  – 21 state attorneys general & at least one governor have filed lawsuits.
  – 40 state legislatures have introduced proposals to nullify the individual mandate.

• Basis for challenges:
  • The individual mandate.
    – Congress cannot coerce individuals to make private purchases & impose penalties for noncompliance.
      » Cannot penalize economic inactivity
  • The Medicaid expansions & health insurance exchanges:
    – State required to spend money they don’t have
    – Coercive encroachment on states’ rights.
    – Violations of 10th amendment?

The Constitutional Challenge to Health Reform: The Individual Mandate

• Basis for defense:
  • The individual mandate.
    – Commerce clause:
      » Failure to buy insurance affects interstate commerce by imposing costs on others (e.g., providers, other households).
      » Mandate required for effective performance of health insurance markets whose operations affect interstate commerce.
    – General Welfare & Commerce Clauses:
      » Mandate akin to a tax & Congress can authorize taxes.
    – Supremacy clause:
      » Congress can impose penalties for noncompliance.
  • The Medicaid expansions & health insurance exchanges:
    – Large federal subsidies to support Medicaid expansions.
    – Federal government will run exchanges if states fail to do so.
    States not required.
The Constitutional Challenge to Health Reform: The Individual Mandate

- By a vote of 5-4, the Supreme Court ruled in favor of the individual mandate, viewing it constitutional under Congress' power to tax and raise revenues.
  - Rejected constitutionally under the Commerce Clause.

- Why mandate coverage?
  - Basic issue of equity or fairness: Health care as both a right & a responsibility.
  - To the extent that they are able to, individuals should bear the costs of their health care & should not shift the costs to other parties.
  - Premium credits for those with incomes between 138% - 400% FPL.

- Basic issue of efficiency:
  - Avoid problem of adverse selection in insurance pools and instability in insurance markets.
  - Experience of NJ HIP
  - Contribute to affordability of coverage.
  - Encourage care in more appropriate settings and timely receipt of care.

Two-Thirds Have Unfavorable View Of Individual Mandate/Fine

As you may know, the health reform law will require nearly all Americans to have health insurance by 2014 or else pay a fine. Would you say you feel very favorable, somewhat favorable, somewhat unfavorable or very unfavorable about that provision of the law? Could you tell me in your own words what is the main reason you have a favorable/unfavorable opinion?

The Constitutional Challenge to Health Reform: The Medicaid Expansions

- The ACA will made Medicaid available to all persons with incomes up to 138% of FPL in 2014.
  - To prompt states to comply with this provision, the federal government proposed withdrawing Medicaid funding for non-compliant states.

- The Court ruled 7-2 that the federal government could not withhold Medicaid funding if states did not participate. expansions.
  - Viewed as a coercive exercise of federal power.
The ACA’s Medicaid Expansion

- Coverage implications:
  - Full expansion of the newly eligible would increase Medicaid enrollment by 21.3 million by 2022.
  - Combined with other ACA provisions, the expansions would reduce the number of uninsured by 48% over this period.
  - If no states adopt the expansion, the number of uninsured would decline by only 28% over this period.

- Cost implications:
  - The federal government will fund the vast majority of increased Medicaid costs.
    - Federal government will pay 100% of expansion costs for first 3 years & at least 90% thereafter.
  - The additional costs to states of implementing the expansion is small compared to total state Medicaid spending.
  - States as a whole are likely to see net savings from the Medicaid expansion.

Key issue: Will full Medicaid expansion take place?

- Key issue: Will all states voluntarily participate?
  - 17 Governors opposing expansion
  - 22 Governors supporting expansion
  - 11 Governors undecided
    - Some states may view incremental costs of expansion as prohibitive.
    - Some states (CT, DE, MA MD, ME, NY, VT) achieve savings.
    - Other states (AL, GA, LA, MS, SC, OK, TX) do not plan to participate in Medicaid expansion.
    - Recently, NJ, Florida, Arizona, Michigan, Nevada, North Dakota, & Ohio have decided to participate.
    - However, a number of state legislatures still need to approve the expansions.
      - E.g., Florida legislature recently voted against expansion.
  - Impact on coverage reduction: 28% to 48% by 2022.
    - Without expansions, persons with low incomes may be ineligible for health exchange subsidies.
    - However, may be pressure by hospital industry to expand Medicaid to offset reductions in DSH payments and Medicare payments.

Health Insurance Exchanges (HIEs)

- States have several options with regard to HIEs
  - Establish own exchange; partner with the federal government;
  - Default position: federally-run exchange.
    - Opponents of expansion contesting whether subsidies can be made available in federal exchanges.
    - States have by December 14th to decide on state-based HIE, February 14, 2012 for partnership exchange.
  - Gov. Christie has vetoed bill to implement a state-run HIE.
    - NJ will opt for federally-run exchanges.
    - Note that NJ already has an infrastructure to manage state-based individual and SHOP exchanges (through IHCP & SEHBP).
Health Insurance Exchanges (HIEs) – Current Concerns

- Will states default to federal HIEs?
  - To date:
    - 17 states & DC will establish state-based HIEs.
    - 10-12 states will opt for state-federal partnership.
    - 17 – 20 states may opt for federally-run exchange.

- Will HIEs be fully operational by January 1, 2014?
  - Will they be ready to enroll consumers on October 1, 2013?

- How will states determine essential health benefits (EHBs)?
  - How much variation in EHBs across HIEs?
  - Ten broad categories of EHBs but states can select within each.
  - States defining EHBs as those provided by largest plan in state’s small group market.
  - However, to comply, states must include certain additional benefits.

- Will budget negotiations and challenges limit funding for HIE subsidies?
- How will states fund and effectively manage the HIE infrastructure?
- Will HIEs yield effective insurer competition?
- Will HIEs effectively eliminate risk-selection?
- Will HIE coverage “crowd out” of ESI?

How Will Employers Respond to HIEs?

- Small firms are exempt from the ACA’s “play or pay” mandate:
  - Tax credit for firms with 25 or fewer FTE employees & annual average wages of < $25,000. Credit up to 35% of employer contribution, 2010 – 2013.
  - Firms with < 50 FTE employees are exempt from the requirement of having to provide coverage.

- Key issue: will employers reduce size or use more part-time workers to avoid coverage requirements?
- HIE individual coverage is an alternative to ESI: Will employers drop ESI?
  - In theory, firms with <= 50 FTE employees will decide to drop coverage and send their employees to the HIE if:
    - The savings from dropping coverage > penalties imposed by doing so.
  - Employees will seek HIE coverage if the subsidy from HIE coverage > tax subsidy from ESI + (OOP premium difference from ESI coverage).
How will Employers Respond?

• Employer Penalties:
  – Penalties for employers >= 50 workers if:
    • Don’t offer coverage / offer coverage and have at least one full-time employee receives a premium tax credit ($2000 penalty per full time worker w/ first 30 workers exempt).
    • Employers that offer coverage to workers with incomes < 400 FPL with premiums between 8% and 9.8% of income required to offer a voucher if employee chooses to enroll in the health exchange.
  – Most simulation models: impact on ESI to be minimal.

How Will Employers Respond?

• Reasons why employers won’t drop coverage:
  – ESI still viewed as necessary to compete for and retain labor.
  – Employers won’t save $ by dropping coverage – they have to pay workers the value of their productivity so wages or other compensation will rise.
  – In general, only low-wage workers benefit from HIE premium and cost-sharing subsidies and employers hire a mix of workers.
    • Only worker <250% FPL likely to benefit from entering the HIE.
    • However, recent concern that some small firms with healthy workers will self-insure to avoid costly benefit requirements.
      – Can worsen risk composition of small group health insurance market.

Issue of Affordable Health insurance

• As noted, premium credits available to those whose out-of-pocket premium costs > 9.5% of income.

• At issue: what are the relevant premium costs?

• IRS has ruled that it is out-of-pocket cost of coverage for a single individual, not for a family.
  – That is, what a worker would pay for self-only coverage.

• Since costs of individual coverage much less than family coverage, credit will do little to address issue of affordability for those with family coverage.

• Concern that available premium credits will be insufficient to cover other family members, especially children.
Early Results:
ACA Expansion of Young Adult Dependent Coverage

- Effective with first renewal starting Sept. 23, 2010
- All private plans with family coverage
- Young adults to 26 years old
- "Grandfathered" plans exempted only if young adults are offered own employer plan and only until 12/2013
- Non-discrimination, same benefits, no added premium for family plans
- Descriptive evidence of high take up
  - Drop of 2.5 million uninsured young adults from 9/2010 to 6/2011.
  - Consistent with anecdotal reports and employer survey findings.

Key Differences Between the ACA and State Dependent Coverage Laws

**ACA**
- All young adults to 26.
- No residency, demographic, or other exclusions.
- Applies to all plans, including self-funded.
- No cost beyond standard family premium.

**State Laws**
- Age limits vary, max. 31 (NJ).
- Typically limited to unmarried, no dependents, in-state except FT students; some require financial dependency
- Does not apply to self-insured plans.
- Nine states require or allow added premium.

Diff-in-Diff Estimates Post-ACA Change in Coverage

Models without ACA-state law interaction terms

<table>
<thead>
<tr>
<th>Percentage Point Change</th>
<th>All States</th>
<th>Non-Reform States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Non-Spouse Dependent</td>
<td>5.0</td>
<td>4.3 *</td>
</tr>
<tr>
<td>Private Self or Spouse</td>
<td>0.6</td>
<td>0.7 *</td>
</tr>
<tr>
<td>Public</td>
<td>-2.1</td>
<td>-1.9</td>
</tr>
<tr>
<td>Uninsured</td>
<td>-3.5</td>
<td>-3.6</td>
</tr>
</tbody>
</table>

* p<0.001; * p<0.05
Early Impact of the ACA

- Pre-existing condition exclusions:
  - Eliminated for children (0-10), for adults in 2014.
- Minimum insurer loss ratios:
  - 80% in small group & individual market;
  - 85% in large group market.
  - $1.1 billion in rebates received by 12.8 million individuals & employers.
- Tax credits to employers w < 26 workers & average wages < $50K.
  - States to approve trends in premiums and recommend whether plans should be excluded from health insurance exchanges.
- Medicare:
  - $250 rebate to Medicare Part D beneficiaries who reach "doughnut hole".
  - Medicare to be phased out by 2020.
- Cannot rescind coverage due to illness.
- No lifetime limits on the dollar value of coverage.
Challenges Facing the ACA

Challenges Facing Reform Provisions

- Will cost containment work?
  - “. . . every cost-cutting idea that every health economist has brought to the table” is in the ACA (K. Sebelius, Secretary, DHHS)
- Will the ACA be successful in “hostile state environments”?
- What about provider supply?
- Will subsidies be adequate?
  - Tax credit for HIE coverage if premium costs to employee > 9.5% of adjusted gross income.
  - However, IRS has ruled that subsidies for HIE coverage based on employee contribution to single not family coverage.
- How will employers behave?
- How will insurers behave?
- Will the health care & insurance markets become more concentrated?

Challenges Facing Reform Provisions

- What will happen to health insurance premiums?
  - Will mandated insurance be affordable?
  - For young adults?
- What will be the impact of taxing “Cadillac” health plans?
- What will reform really cost?
- Will reform withstand further constitutional challenges?
  - E.g., suit by Liberty University regarding employer mandate.
- Will reform withstand efforts to rescind or limit effectiveness?
  - Rep. Ryan (R-Wisc.) budget proposal includes provision to rescind ACA’s premium subsidies & Medicaid expansion.
  - Speaker Boehner (R-Ohio) has said that all ACA provisions are on the table in spending cut deliberations.
Will Incendiary Issues Continue to Distort the Likely Impact of Reform & Influence Public Opinion

- Past distortions of reform:
  - Death squads.
  - Rationing health care.
  - Socialized medical care.
  - Cannot keep current coverage
  - Limiting health plan choice
  - Government will pay for care by directly withdrawing funds from individual bank accounts.
  - Tax dollars to provide health benefits to illegal immigrants and to finance abortions.
Do you think you and your family will be better off or worse off under the health reform law, or don't you think it will make much difference?

Percent who say they feel favorable about each of the following elements of the health reform law:

<table>
<thead>
<tr>
<th>Element</th>
<th>Total</th>
<th>Dem</th>
<th>Ind</th>
<th>Rep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax credits to small businesses</td>
<td>82%</td>
<td>93%</td>
<td>72%</td>
<td>63%</td>
</tr>
<tr>
<td>Require many-to-understand plan summaries</td>
<td>93%</td>
<td>89%</td>
<td>74%</td>
<td>86%</td>
</tr>
<tr>
<td>Medical underwriting by employers</td>
<td>71%</td>
<td>63%</td>
<td>79%</td>
<td>67%</td>
</tr>
<tr>
<td>Health plan secret approval</td>
<td>75%</td>
<td>70%</td>
<td>80%</td>
<td>77%</td>
</tr>
<tr>
<td>Medicaid expansion</td>
<td>89%</td>
<td>92%</td>
<td>79%</td>
<td>82%</td>
</tr>
<tr>
<td>At least taking for preventive services</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>Medical loss limits</td>
<td>54%</td>
<td>70%</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>Employer mandate/penalty for large employers</td>
<td>54%</td>
<td>74%</td>
<td>51%</td>
<td>41%</td>
</tr>
<tr>
<td>Lower Medicare penalty for upper income</td>
<td>57%</td>
<td>65%</td>
<td>69%</td>
<td>50%</td>
</tr>
<tr>
<td>Tax credits for employers</td>
<td>53%</td>
<td>54%</td>
<td>52%</td>
<td>50%</td>
</tr>
<tr>
<td>Year benefits package, defined by government</td>
<td>51%</td>
<td>66%</td>
<td>37%</td>
<td>20%</td>
</tr>
<tr>
<td>Additional requirements/penalty</td>
<td>52%</td>
<td>65%</td>
<td>33%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Note: Sample size of separate half samples, Ferguson wording determined. See Togheter: http://www.kff.org/kaiserpolls/8285.cfm for complete analysis.

Source: Kaiser Family Foundation

Do you think it will make much difference?

Many Elements Of Health Reform Law Continue To Be Popular Across Parties

Unfavorable Views Of ACA Outstrip Favorable Among Seniors
After Election, Proportion Wanting Repeal Ticks Down

What would you like to see Congress do when it comes to the health care law?

Source: Kaiser Family Foundation
Health Tracking Polls

Four In Ten Say They Are “Confused” About Health Reform Law; Equal Shares “Angry” And “Enthusiastic”

Percent who say that each of the following describes their feelings about the health reform law:

Source: Kaiser Family Foundation
Health Tracking Polls

Majority Disapprove Of Cutting Off Funding For Implementation

Some lawmakers who oppose the health reform law say that if Congress isn’t able to repeal the law, they should try to stop it from being put into place by cutting off funding to implement it. Whether or not you like the health reform law, would you say you approve or disapprove of cutting off funding as a way to stop some or all of health reform from being put into place?

Source: Kaiser Family Foundation
Health Tracking Poll (conducted July 17-23, 2012)
Summing Up

- Imperatives regarding costs and coverage have provided impetus for health reform.
- ACA is a complex undertaking that will impact nearly all aspects of health care delivery and insurance coverage.
- ACA is not a radical departure as it builds on existing systems of health care delivery and insurance.
- Provisions will be phased in over time.
- Expectations regarding cost savings remain uncertain.
- Early ACA results are encouraging.
- ACA will face political & economic challenges over time which may alter provisions.
- Key challenge: controlling health care spending.