



March 19, 2009

HEALTH REFORM PACKAGE REPRESENTS HISTORIC CHANCE TO EXPAND COVERAGE, IMPROVE INSURANCE MARKETS, SLOW COST GROWTH, AND REDUCE DEFICITS

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The health reform legislation now before Congress represents a historic opportunity to make significant progress in three critical areas: expanding the availability and affordability of health coverage, instituting much-needed improvements to the flawed health insurance marketplace, and taking steps to slow the relentless growth in health care costs.

Not only would this legislation produce the greatest gains in health coverage since the enactment of Medicare and Medicaid 45 years ago and provide stability and security for tens of millions of Americans who now have health insurance, but its costs are also fully offset; the legislation would reduce budget deficits by \$138 billion over ten years, according to the Congressional Budget Office (CBO). CBO estimates that the legislation would continue to reduce deficits in years after 2019, to a greater extent than under the Senate-passed bill by itself.

The Senate health reform legislation and the limited, but significant, improvements made to it in the accompanying reconciliation bill may represent the last hope, perhaps for many years to come, to enact comprehensive health reform legislation. The highlights of the health reform package include:

- **Expanding coverage.** Under the legislation, 95 percent of non-elderly legal residents of the United States would have health insurance by 2019. The legislation would expand Medicaid and provide subsidies to help low- and moderate-income people purchase private health insurance. Relative to current law, the bills would reduce the number of uninsured by 32 million by 2019, according to CBO — 1 million more than under the Senate bill alone.¹
- **Reforming health insurance markets.** The legislation includes long overdue reforms that would improve access to health insurance for people at all income levels and for employers seeking to provide coverage to their employees. Shortly after enactment, the legislation would bar lifetime limits on benefits and begin reining in harmful insurance-industry practices such as

¹ Congressional Budget Office, “Letter to the Honorable Nancy Pelosi,” March 18, 2010.

rescissions, under which insurers revoke coverage when beneficiaries become ill. By 2014, the legislation would bar insurers from denying coverage or charging higher premiums to women and people with pre-existing health conditions, restrict insurers' ability to charge higher premiums to older individuals, and prohibit insurers from setting annual limits on benefits.

The legislation also would establish state-based health insurance exchanges to make a range of health coverage options available to individuals and small employers and foster competition among insurance companies based on the price and quality of their products. Plans would have to meet minimum standards regarding coverage and cost-sharing protections for enrollees.

- **Slowing health care cost growth.** The legislation would take a number of steps, particularly within Medicare, to institute efficiencies to lower costs and to improve the quality of care by beginning to change the way health care is delivered. In addition, the legislation includes an excise tax on high-cost health plans, which would help slow the rate of health care cost growth over the long term. The legislation would also extend the solvency of the Medicare Hospital Insurance Trust Fund.²

Reforms Expand Coverage and Make Insurance More Affordable

The health reform legislation would expand coverage to 32 million uninsured people through a significant expansion of Medicaid, as well as premium and cost-sharing credits for low- and moderate-income individuals and families who do not have employer-based insurance and who do not qualify for Medicaid or Medicare.

Premium and Cost-Sharing Credits for Low- and Moderate-Income People

Individuals and families who have incomes above the level needed to qualify for Medicaid but below 400 percent of the poverty line would receive "premium credits" to help them purchase health insurance in the new health insurance exchanges (discussed below). For example, under the health reform legislation, a family of three earning \$32,000 (175 percent of the poverty line for a family of that size) would receive a credit that would limit its annual premium to about \$1,500 (if the health reform bill were in effect in 2010). In addition, the legislation would provide additional cost-sharing subsidies (that is, assistance with deductibles and copayments) to people earning less than 250 percent of the poverty line to ensure that they can actually afford to see a doctor and seek care. The maximum out-of-pocket costs a family of three earning \$32,000 would have to pay each year (in addition to the insurance premiums) would be about \$2,000.

Expanded Medicaid Eligibility for the Lowest-Income People

The plan would expand Medicaid up to 133 percent of the poverty line for all children and adults younger than 65 who are lawfully residing in the United States and not eligible for Medicare. This would mean that millions of low-income parents, as well non-disabled low-income adults who do not have dependent children (and who are generally ineligible for Medicaid today except in a small

² The improvement in solvency would be the result of both Medicare savings in the legislation and the increase in Medicare tax revenues. See Chuck Marr, "Changes in Medicare Tax on High-Income People Represent Sound Additions to Health Reform," Center on Budget and Policy Priorities, March 4, 2010.

number of states with waivers), would become newly eligible for health coverage through Medicaid. The federal government would pick up 100 percent of states' Medicaid costs related to this expansion for three years, with that percentage phasing down to 90 percent for 2020 and subsequent years. Recognizing the need for increased capacity to serve new enrollees, the plan would also increase primary care provider payments to 100 percent of Medicare rates during 2013 and 2014, with the federal government covering the full cost of these rate increases.

Medicaid is the most cost-effective way to provide comprehensive and affordable coverage to people with very low incomes and thereby ensure that the low-income uninsured gain coverage. Medicaid beneficiaries generally do not pay premiums and are required to pay only modest co-payments. Medicaid covers a broad array of services and supports well-suited to the needs of low-income people (especially children and people with disabilities), who are more likely than people with higher incomes to be in fair or poor health. Medicaid is also significantly less costly, on a per-beneficiary basis, than private insurance (after adjusting for health status), largely due to its lower provider rates and administrative costs.

Reforming the Insurance Marketplace

The health reform package includes a number of important reforms to the health insurance market that would greatly improve access to affordable and comprehensive health insurance coverage for people at all income levels, as well as employers.

Near-Term Improvements

Some reforms would happen soon after the plan becomes law. Within months, insurers that offer coverage of policyholders' children (including in existing plans) would be required to allow adult dependents younger than 26 to be added to such coverage.³ In addition, new insurance plans would be barred from excluding children's pre-existing conditions from coverage and would have to cover certain preventive services at no charge to enrollees. The legislation temporarily increases funding for high-risk pools to provide near-term help to people with pre-existing health conditions, who otherwise face rejection or very high premiums in the current individual insurance market.

Under the legislation, consumers would gain significant protection from harmful insurer practices that are prevalent in the market today. Soon after enactment, both new and existing insurance plans would be barred from placing limits on the dollar value of benefits that an enrollee can receive during his or her lifetime. And insurers would face federal restrictions on their ability to impose annual limits on coverage of specific benefits in new insurance plans and existing group plans, before a broader ban on annual limits of "essential" health benefits takes effect in 2014.

Insurance companies would be required to spend a minimum portion of the premiums they collect on health care and quality efforts, rather than non-health costs such as advertising and administration. Insurers that fail to allocate sufficient resources to health care would be required to provide rebates to their customers to make up the difference.

³ For existing group health plans, the requirement to extend coverage to adult dependents would apply only when dependents lack an offer of employer coverage.

Far-Reaching Reforms Starting in 2014

The legislation's most sweeping reforms would begin in 2014, when new insurance exchanges and broader modifications to insurance-market rules would help even more people gain coverage. The plan would prevent insurance companies operating in the individual and small-group markets from denying coverage or charging higher premiums to people who have health problems. It would also limit insurers' ability to charge higher premiums to individuals simply because they are older; premiums for the oldest enrollees could be no more than three times the amount charged to the youngest people. New insurance plans, as well as existing group plans, would no longer be able to exclude pre-existing conditions from insurance policies.

Insurance Exchanges

The launch of new insurance exchanges, which states would be expected to administer, would make it easier for consumers and employers to find decent coverage and help foster competition among insurance companies based on the price and quality of their products. Participating insurers would have to meet new federal criteria regarding marketing practices, quality of care, and the choice of health providers available to enrollees. The exchanges would be required to consider whether insurers are offering products at reasonable prices when deciding which companies could participate in an exchange. And insurers would have to supply information about plans in a standardized format so that consumers could make comparisons.

All plans provided within the new insurance exchanges, as well as new insurance plans available in the individual and small-group markets outside the exchanges, would have to meet minimum standards regarding covered benefits. The plans would have to cover a list of essential benefits (such as hospital and physician services and prescription drugs), include a limit on the annual out-of-pocket costs enrollees would have to pay for covered services, and provide coverage that meets a minimum level of comprehensiveness. Such rules would help fill in critical gaps in coverage that many people face in existing insurance markets.

Responsibility Requirements for Individuals and Employers

The health legislation would appropriately require most people to have health insurance or pay a penalty, an important component of comprehensive reform. Without such a requirement, many people in good health would wait until they became sick to buy insurance. That would cause the pool of people buying coverage through the exchanges to be less healthy on average and consequently would result in higher premiums for those who do buy insurance.

Requiring most individuals to have insurance also is necessary to end many of the troubling practices that insurers use today, such as denying coverage to people with health problems or charging them higher premiums. It also makes it more likely that health insurers will focus on managing costs and improving quality, rather than working to "cherry pick" the healthiest, most profitable enrollees, as they typically do in the current system.

To encourage employers to continue providing insurance coverage to workers and not shift costs to the federal government, the legislation also includes an employer responsibility requirement. Employers that do not offer coverage generally would pay a penalty if any of their full-time workers obtains a premium credit to buy coverage in the exchange. A penalty would also apply to employers that offer health insurance coverage but whose workers receive premium credits. Firms with fewer than 50 full-time equivalent workers would be exempt from these penalties.

Health Reform Package Contains Wide Range of Cost-Control Measures

The legislation contains a wide range of measures to restructure the U.S. health system and slow the growth of health care costs, particularly Medicare costs. It begins to advance most of the strategies that health policy experts consider promising ways to reduce the growth of spending.

Efficiencies in Medicare and Medicaid

The legislation includes a number of provisions that would make Medicare more efficient, providing significant savings that would help pay for health reform. Many of these cost containment provisions are in line with recommendations of the nonpartisan Medicare Payment Advisory Commission — recommendations that Congress has heretofore ignored and is unlikely to adopt in the absence of health reform. In dollar terms, the bulk of the bills' reductions in projected Medicare expenditures come in three areas:

- **Reducing Medicare Advantage overpayments.** MedPAC estimates that in 2010, Medicare will pay private insurers that participate in Medicare Advantage 13 percent more per beneficiary, on average, than it would cost to cover these beneficiaries in traditional Medicare. The legislation would substantially scale back these overpayments, saving \$132 billion over ten years.
- **Reducing the annual updates in Medicare fee-for-service payment rates.** Medicare payment rates for covered services are updated annually according to formulas specified in law. The legislation would reduce annual payment updates to hospitals, skilled nursing facilities, hospices, ambulatory surgical centers, and certain other providers to account for improvements in economy-wide productivity. It would also reduce payments to home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities, as MedPAC has recommended. The legislation would save nearly \$196 billion over ten years from such changes.
- **Reducing prescription drug costs.** The reform package would increase the rebates that drug companies pay for drugs that Medicaid covers, saving \$38 billion over ten years.

Payment Advisory Board

The legislation would establish an Independent Payment Advisory Board to develop and submit proposals to slow the growth of Medicare and private health care spending and improve the quality of care. The President would nominate the board's 15 members, who would require Senate confirmation, for staggered six-year terms.

If the projected growth in Medicare costs per beneficiary in 2015 and thereafter exceeded a specified target level — which it almost certainly would do in many years — the board would be required to produce a proposal to eliminate the difference. The board could not propose increases in Medicare premiums or cost-sharing or cuts in Medicare benefits or eligibility criteria; it would focus on proposals for savings in the payment and delivery of health care services.

The board's recommendations would go into effect automatically unless both houses of Congress passed, and the President signed, legislation to modify or overturn them. If the board recommended changes that the President supported, the President could veto any congressional attempt to block them, and a two-thirds vote of both the House and Senate would be required to override the veto.

Systemic Reforms in Health Care Payment and Delivery

The health reform package would take numerous important steps to begin restructuring the health care payment and delivery systems to move away from paying providers for more visits or procedures and toward rewarding effective, high-value health care. Among many things, it would reduce Medicare payments to hospitals with high readmission rates to encourage them to do a better job of preventing avoidable readmissions. It would also create an alternate payment model to reward Accountable Care Organizations — physician-led organizations that take the responsibility for the cost and quality of the care they deliver.

These and many other provisions in the legislation are not estimated by CBO to save much money in the next ten years because their effects, while promising, are not proven at this point. But they constitute important initial efforts to slow the growth of health care costs. Moreover, the proposed reforms are likely to reinforce each other and have a combined effect that exceeds the sum of the individual parts. If given the appropriate financial incentives, providers are likely to seek ways to strengthen the delivery of primary care, use the results of comparative effectiveness research to select high-value treatments, and employ electronic health records (for which the February 2009 recovery act provides substantial funding) to manage and coordinate care.

Many of the proposals involve Medicare, which has been a leader in developing and testing effective payment reforms that private insurers later adopt widely. As the largest U.S. purchaser and regulator of health care, Medicare exerts a major influence on the rest of the health care system; its reimbursement and coverage policies have served as models for private insurers and other public programs. Consequently, these reforms have the potential to slow health care growth not only in Medicare but throughout the U.S. health care system.

Excise Tax on High-Cost Plans

The health reform package includes an excise tax on high-cost insurance plans that promises to help slow the growth of health care costs. The tax would begin in 2018 and would apply to the portion of the value of health plans that exceeds \$10,200 for individuals and \$27,500 for families (or larger amounts in the case of retirees and people in certain high-risk professions). Several provisions in the reconciliation bill improve the excise tax included in the Senate bill. For example, the reconciliation bill adjusts the tax for all variation in costs resulting from the age and gender of enrollees, so that plans that have high costs because they cover large numbers of older workers or women are protected from any disproportionate impact. The reconciliation bill increases the tax

thresholds compared to the Senate bill and makes other changes that will cause the excise tax to take longer to have a significant effect on health care costs. However, it eventually should achieve largely the same results in containing cost growth.