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**National Health Reform:
The Patient Protection and Affordable Care Act of 2010**

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Disclosure Statement

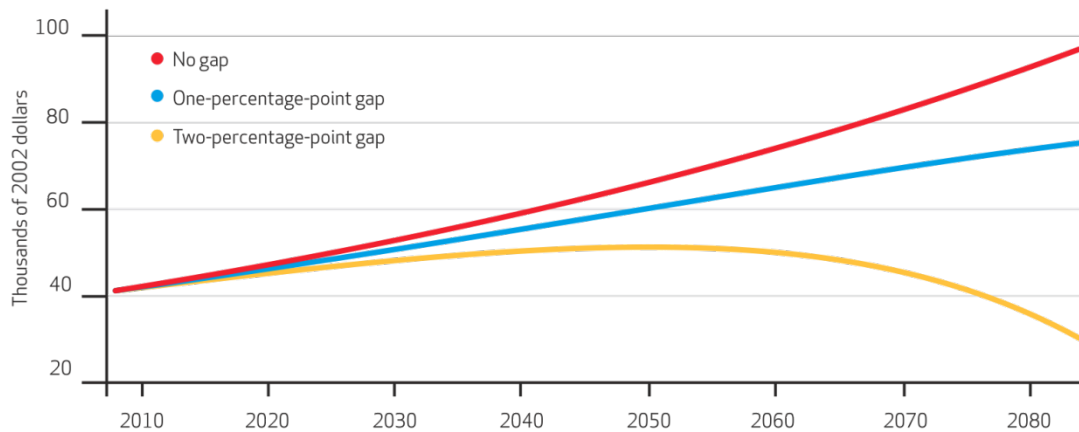
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Background: The Impetus for Reform

The Patient Protection and Affordable Care Act (PPACA) of March 2010 represents the most significant government overhaul of the US health care system since the passage of Medicare in 1965. It includes a wide range of provisions, including expanded insurance coverage, regulation of the private insurance market, and longer-term changes to care delivery aimed at improving quality of care and containing the nation's high and growing health care costs. Proponents of reform point to widely acknowledged problems with the US health care system: approximately 46 million Americans were uninsured in 2008,¹ and this number has likely grown through the economic downturn.² Approximately 25 million more are "underinsured," meaning that they spend high percentages of income on deductibles and out-of-pocket expenses and often forgo care despite having some coverage.³ Although the majority of the US population under the age of 65 has employer-sponsored health insurance, a growing number of employers, particularly small businesses, are scaling back benefits or dropping coverage as premiums rise. Roughly 80% of the insured have at least one worker in the family.⁴ Those with employer-based coverage can find themselves in "job lock," afraid to change jobs for fear of losing coverage. And for the insured, premiums consume a growing portion of household budgets, rising 119% between 1999 and 2008 while median family income grew just 29%.⁵

The US stands alone among developed nations in not providing some form of near-universal insurance coverage. Yet the US spends more on health care than any other country by a considerable margin. As a percent of gross domestic product (GDP), the US spent nearly 80% more (16% of GDP) than the Organisation for Economic Co-operation and Development (OECD) average in 2008 (9% of GDP).⁶ That same year, the US outspent the next-highest-spending countries—Norway, Sweden, and Switzerland—by more than 50% in adjusted dollars per capita.⁷ Part of the US's high health spending is a consequence of global leadership in medical innovation and widespread adoption of new medical technologies.⁸ But the growth of health spending is unsustainable, now outpacing GDP growth by an average of 2.5% annually for the past several decades.⁹ Chernew et al. project that, if current trends continue, 119% of the increase in real per-capita income through 2083 will go to health care, crowding out government spending on other services (e.g., housing and education) and hindering private-sector competitiveness.¹⁰ As shown in the figure below, income available for non-health spending will decline even if the difference between health spending and GDP growth is reduced from current levels to 2%. Further cost containment is necessary for spending growth to be possible in other sectors.

Income Available for Non-health Goods and Services under Different Gaps Between Growth Rate of Health Spending and Growth Rate of GDP (Projected) Per Capita, 2008–2084¹¹



The prevailing fee-for-service system of reimbursement to providers helps drive high health spending by incenting a high volume of service delivery. High spending is exacerbated by the highly fragmented structure of the US health care system, with lack of care coordination leading to redundant testing and costly medical errors.¹²

Indeed, more health spending does not appear to buy better health or higher-quality care. The US fares poorly in international comparisons of measures such as infant mortality rates and equity of, access to, and quality of care.^{13,14} A 2003 article in the *New England Journal of Medicine* reported that adults in the US received recommended care less than 55% of the time.¹⁵ Moreover, researchers at the Dartmouth Atlas Project have documented substantial variation in cost and intensity of care within the US. Higher-spending areas, in fact, have outcomes that are similar or worse than those of lower-spending areas.¹⁶ While some argue that high health spending is justifiable if it pays for favorable outcomes and high-quality care, evidence suggests the US is not getting its money's worth.

Congress passed the Patient Protection and Affordable Care Act to address many of these problems. The bill affects nearly every stakeholder in health care—patients, providers, insurance companies, employers, pharmaceutical and medical device companies, regulators, and other state and federal governmental bodies. It couples near-term expansion of health insurance coverage with a longer-term strategy for reforming care delivery and payment with the goals of controlling costs and improving quality.

Provisions of the Patient Protection and Affordable Care Act of 2010

The PPACA contains many provisions that can be grouped into four major categories of reform: expanded insurance coverage, delivery and system reform, cost containment, and financing. (Some provisions work to achieve multiple aims simultaneously.) This case does not cover all aspects of the bill in detail.

Expanded insurance coverage. The PPACA seeks to extend insurance by 2019 to an estimated 32 million people of the people who are currently uninsured.¹⁷ Several provisions in the PPACA work together to expand coverage.

First, a series of private insurance regulations protect and expand access to insurance coverage. The PPACA's "guaranteed issue" forbids insurers from denying coverage for any reason, including preexisting conditions. This provision aims to ensure that the sickest patients can get care and to protect consumers from insurance company abuses. The law also prohibits insurers from capping the amount of annual or lifetime coverage and from rescinding coverage except in cases of fraud. Insurers will also be unable to price plans differentially based on health status or gender, though they remain able to vary premiums based on age and tobacco use (within limits), area of residence, and family size. Coverage must be available to those wishing to purchase it within 90 days. Finally, dependents (i.e., children) are eligible to remain on their parents' insurance until the age of 26.¹⁸ While this provision helps to expand coverage to young adults, who have a high rate of uninsurance, those with preexisting conditions may face exclusions until guaranteed issue takes effect in 2014.¹⁹

In the meantime, individuals with preexisting conditions and without insurance for at least six months will be eligible to enroll in so-called temporary "high-risk" insurance pools. (The pools are "high-risk" to insurers because enrolled individuals will likely be expensive to cover.) States have the option to bolster existing high-risk pools, start their own high-risk pools if none exist, or let the federal government run their pools. (As of August 2010, 22 states had indicated they would leave the task to the government.²⁰) Health plans participating in the pools must cover at least 65% of enrollees' health care costs. Coverage in the pools was slated to begin on August 1, 2010. When the high-risk pools expire in 2014 and guaranteed issue takes effect, high-risk individuals will be able to enroll in state insurance exchanges, described below.

Experiences in Kentucky, Maine, New York, and Washington State have shown that guaranteed issue alone can cause destabilizing premium increases in the individual and small-group (i.e., small business) markets.²¹ These increases have been the result of adverse selection, in which sicker-than-average individuals buy insurance while healthier individuals go without. Adverse selection drives up the average per-enrollee cost to insurers and can lead to a spiral of rising premiums and further adverse selection.²² Historically, plans have managed adverse selection by denying, limiting, and delaying coverage and by marketing insurance to healthy individuals. With guaranteed issue, however, plans will be required to cover more expensive patients. To avoid adverse selection and consequent premium inflation, the PPACA includes an individual mandate, requiring most Americans to have some basic level of health insurance beginning in 2014. By expanding the number of healthy individuals with insurance, an individual mandate dilutes the risk to insurers of covering sick patients and thereby restrains the price of premiums. (Adverse selection is less problematic in the large-business insurance market because large companies tend to have a relatively representative distribution of risk among insured employees.²³) Groups exempt from the mandate include American Indians, persons with religious objections, persons with incomes below the threshold for tax filing, and persons for whom the cheapest available plan would cost more than 8% of income, among others.²⁴ Eligible individuals and families who fail to get coverage will face a penalty of the greater amount of either \$695 per individual (up to \$2,085 per family) or 2.5% of income, phased in gradually over three years. In Massachusetts, where an individual mandate began in 2007 as part of a similar set of health insurance reforms, compliance with the mandate has been high, and the rate of uninsurance has fallen below 3%.²⁵

To create a more competitive and transparent health insurance market and drive down the price of insurance purchased by individuals and small businesses, the PPACA calls for the states to establish insurance exchanges beginning in 2014. Separate exchanges will be established for individuals (American Health Benefit Exchanges) and for small businesses with fewer than 100 employees

(Small Business Health Options Program [SHOP] Exchanges). States may allow larger businesses to join the SHOP Exchanges beginning 2017 at their discretion. By amassing a critical mass of small business and individuals (14 million of whom buy insurance through the individual, or “nongroup,” market²⁶), the exchanges can pool risk and negotiate premiums like large-group purchasers. Additionally, insurers participating in the exchanges will be required to offer plans that meet a set of minimum standards, to use a uniform enrollment form, and to present details of plans clearly to consumers. Exchanges will offer four levels of coverage (bronze, silver, gold, and platinum), plus catastrophic coverage (reduced coverage up to the federal out-of-pocket limit of \$5,950 for individuals and \$11,900 for families in 2010) to individuals under 30 or who are exempt from the individual mandate. Though the PPACA does not include a government-run plan (“public option”), each exchange will offer two multistate plans, ostensibly to achieve greater risk pooling and thus greater cost savings.

The high cost of premiums poses a considerable challenge to many individuals and families. Several options are available to help individuals with lower incomes find coverage and comply with the mandate. First, individuals and families with incomes below 133% of the federal poverty level (FPL) will be eligible for Medicaid. (The FPL in 2010 is \$10,830 for an individual and \$22,050 for a family of four.²⁷) In 2009, 40 states had Medicaid eligibility cutoffs below 133% FPL,²⁸ so the PPACA will expand Medicaid in these states. Second, two types of subsidies will become available to purchase coverage through the exchanges. Premium subsidies will be available to families with incomes between 100% and 400% of the federal poverty level, administered in the form of tax credits. These premium subsidies will be calculated on a sliding scale so that the cost of insurance is less than a defined portion of income for a given income level, between 2% of income for those at 133% FPL and 9.5% for those at 400% FPL. In addition, cost-sharing subsidies will reduce out-of-pocket costs to a specified percentage below the national out-of-pocket spending limits, depending on income level, for people between 100% and 400% FPL.

Taken together, the individual mandate, penalty, and subsidies should reduce adverse selection in the individual and small-group markets, with adverse selection shrinking further as greater coverage is achieved.

More than 60% of Americans received insurance through their employer in 2007.²⁹ To ease the financial burden on small businesses offering insurance, the government will offer tax credits to small businesses contributing 50% or more of employee premiums, with larger credits for the smallest businesses, beginning in 2010. The PPACA also offers a temporary reinsurance program to enable providers to cover retirees between 55 and 64 (i.e., too young for Medicare coverage). Businesses with more than 50 employees, by contrast, will face penalties for not offering coverage. And companies with over 200 employees will be required to enroll employees automatically in offered plans, though employees will be able to opt out.

Public programs are an important part of health reform. Expansion of Medicaid will account for approximately half of the individuals newly insured. As noted above, the program will expand to all individuals under 65 with income below 133% FPL, including childless low-income adults who have previously been excluded from Medicaid. Additionally, the PPACA expands drug coverage under Medicare (Part D) by closing the “donut hole” coverage gap gradually between 2011 and 2020 and by increasing subsidies for low-income Medicare beneficiaries to purchase prescription drugs.

Importantly, the law creates the Community Living Assistance Services and Supports (CLASS) Program, a supplemental long-term-care insurance program to help cover expenses for adults who, later in life, become functionally and/or cognitively disabled. The program will provide primarily nonmedical services to help the disabled maintain residence in the community. It will be financed entirely by enrollee premiums. Enrollees become eligible for benefits if they have paid premiums for five years and present with a disability expected to last longer than 90 days. The program is expected to save Medicaid \$70 billion over 10 years by keeping enrollees out of institutional settings and preventing some people from falling below the threshold for Medicaid eligibility.³⁰

Finally, to help individuals make sense of federal and state health programs and available insurance options, the Department of Health and Human Services launched www.healthcare.gov in July 2010. The site will consolidate information about high-risk pools, Medicaid, the individual market, and eventually state exchanges.³¹ This “web portal” will ultimately list and compare available coverage options including standardized information about plans that insurers will be required to report, thereby adding further transparency to the process of finding insurance.

Care delivery and system reform. The PPACA contains a number of provisions that aim to improve health care quality, lower costs, or both. First, the law calls for a large array of payment reforms and demonstration projects. These include bundled payment pilots within Medicare and Medicaid, in which providers receive a lump sum to cover all care associated with an injury or illness including inpatient acute care, outpatient follow-up, and rehabilitation. The law also establishes accountable care organizations (ACOs) within Medicare and for pediatric providers within Medicaid. ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group’s clinicians. Providers in ACOs will receive bonuses for controlling costs (a portion of savings below an established spending target) while meeting quality targets.

An Innovation Center within the Centers for Medicare and Medicaid Services (CMS) will develop and test other new payment methodologies designed to improve care and reduce costs. Finally, Medicare will reduce payments to hospitals for preventable readmissions for heart attack, heart failure, and pneumonia (the three conditions for which quality is most widely measured and reported), and for hospital-acquired infections and other adverse events. (An article in the *New England Journal of Medicine* reported in 2009 that 20% of Medicare patients discharged from hospitals are readmitted within 30 days. The estimated cost of these readmissions to Medicare in 2004 was \$17.4 billion.³² In addition to penalizing preventable readmissions, the PPACA further attempts to decrease readmissions by giving providers \$500 million over five years to improve post-discharge care.) Taken together, these reforms, if effectively implemented, should incentivize providers to improve coordination of patient care, implement systems to reduce medical error and inefficient utilization, and invest in process improvement, all of which, policymakers believe, will slow cost growth. Potential savings from these reforms, however, have not been factored into estimates of long-term savings resulting from health reform.

Another provision aimed at improving clinical care is a new Patient-Centered Outcomes Research Institute (PCORI). The Institute will conduct comparative effectiveness research to identify effective treatments, although in the law’s current formulation its findings cannot become mandated care guidelines or guide payment or coverage decisions. It is hoped that the Institute’s research will be incorporated into electronic medical systems and provide point-of-care decision support.³³

The impending influx of newly insured individuals into the market will undoubtedly further strain an already stretched primary care workforce. Accordingly, the law aims to maintain and expand primary care providers to increase access to primary care. It calls for expanded training in primary care and preventive medicine and appropriates \$1.5 billion for the National Health Service Corps over four years, as well as \$11 billion for community health centers.³⁴ Additionally, it increases Medicaid payments to the level of Medicare reimbursement, which in some states will dramatically increase revenue to Medicaid providers. Primary care physicians (PCPs) and general surgeons practicing in areas of health workforce shortages will also be eligible for a 10% “Medicare bonus” between 2011 and 2015.³⁵ These provisions should help mitigate provider shortages for Medicaid and Medicare enrollees.

Finally, the PPACA emphasizes prevention and wellness. Beginning September 23, 2010, new employer-based and individual health plans will be required to cover US Preventive Task Force-recommended preventive services without cost sharing (i.e., without co-pays, coinsurance, or deductible payments). Medicare will cover these same services without cost sharing beginning in 2011. And states whose Medicaid programs cover these services without cost sharing will receive 1% bonus payments from CMS beginning in 2013.

Cost containment. In addition to the aforementioned payment reforms, the PPACA includes other provisions designed to reduce both the level and growth of health spending. These savings will both pay for the law (the bulk of the cost going to subsidies and expanded Medicaid) and, it is projected, will reduce the federal deficit by \$132 billion in the first 10 years and by more than \$1 trillion over the next 10.³⁶

More than half of cost savings will come from Medicare, principally from reduced payments to private plans offering Medicare Advantage and to many Medicare providers (e.g., hospitals, home health, hospice, etc.). (The law does not curb rates for outpatient physician care other than decreasing reimbursement for several types of outpatient imaging.) Reduced payment to Medicare Advantage (Part C) plans, which currently receive up to 18% higher reimbursements than Part B counterparts as a result of the 2003 Medicare Modernization Act, will save an estimated \$132 billion over 10 years. And reduced annual “market basket updates,” i.e., smaller increases in reimbursements to Medicare providers, will save an estimated \$200 billion over 10 years. In addition, a variety of measures to reduce fraudulent claims, waste, and abuse within Medicare are projected to save \$7 billion over 10 years.³⁷

Changes in Medicare payments have always required Congressional legislation, which has limited the government’s flexibility to revise Medicare payment policies. Thus, the law also creates an Independent Payment Advisory Board (IPAB) with the authority to reduce Medicare spending. Beginning in 2014, the IPAB will begin making payment recommendations to Congress; every year that growth in Medicare payments outpaces target growth rates, the Board’s recommendations become law unless Congress passes a substitute that achieves the same cost reductions as the IPAB’s recommendations. Yet experts worry that the IPAB’s power will be too constrained for it to make effective recommendations and that, in the absence of parallel regulation of commercial insurers, large reductions in Medicare reimbursements will prompt providers to drop Medicare beneficiaries for privately insured patients.³⁸ Thus, though it would be politically difficult, an eventual step in cost containment may be rate setting for all payers (i.e., both public and commercial insurers).

Other cost-containment measures apply beyond public programs. All insurers will be subject to administrative simplification guidelines and uniform operating rules to reduce paperwork, yielding an estimated \$20 billion in savings over 10 years.³⁹ Plans will be required to report their medical loss ratio (i.e., the percentage of premium dollars spent on medical care rather than administrative overhead) and provide rebates to consumers if the ratio is below established thresholds (85% for the large-group market, 80% for the small-group and individual markets).⁴⁰ The law also calls for a process by which states review and approve premium increases and report on premium trends. Finally, the law imposes a tax on high-cost employer-sponsored plans (referred to as “Cadillac plans”), effective in 2018. These plans are taxed at 40% of the plan’s value above established thresholds: an annual cost of \$10,200 for individuals or \$27,500 for families. This tax would be paid by employers and is designed to entice employers to offer less generous plans while raising an estimated \$32 billion over 10 years.

Financing. The provisions of the PPACA that expand coverage through subsidies and expanded Medicaid will cost an estimated \$938 billion. This amount will be financed through a combination of a 0.9 percentage point increase in the Medicare Part A payroll tax (currently 2.9% of all wages, split between the employer and earner) for individual earners with incomes over \$200,000 and families with incomes over \$250,000, annual fees levied on the pharmaceutical and private insurance sectors, reduced tax deductions, and savings within Medicare and Medicaid described above.⁴¹

Timeline for Implementing Health Reform

The majority of the PPACA’s provisions, including the individual mandate, establishment of exchanges, and most regulation of private insurance, become effective in 2014. But an important subset of reforms, listed in the table below, will occur before 2014.

Early Implementation Timeline for the Patient Protection and Affordable Care Act⁴²

<i>Year</i>	<i>Major Provisions of the PPACA That Take Effect</i>
2010	<ul style="list-style-type: none"> • Temporary high-risk pools for individuals with preexisting conditions • Temporary reinsurance program for retirees aged 55 to 64 • Federal health web portal (www.healthcare.gov) • Dependent coverage up to age 26 • Cancellations of coverage, lifetime caps, and preexisting condition exclusions for children are forbidden (preexisting condition exclusions end for adults in 2014) • Small-business tax credit begins • Preventive services in new health plans offered without cost sharing
2011	<ul style="list-style-type: none"> • Medical loss ratio reporting required of commercial insurers • Preventive services for Medicare beneficiaries offered without cost sharing • States can begin to expand Medicaid enrollment (req’d by 2014) • Reduced Medicare Advantage payments begin phase-in • CMS Innovation Center launches
2012	<ul style="list-style-type: none"> • Accountable care organizations within Medicare • CLASS program enrollment to open (benefits take effect in 2017)
2013	<ul style="list-style-type: none"> • Increased Medicaid payments up to Medicare rates • Increased Medicare Part A tax rate • Administrative simplification rules take effect

Impact of Reform

How will reform affect states? States will play a critical role in expanding insurance coverage as they regulate their own health insurance markets and administer federal programs. Many already operate high-risk insurance pools. Under the PPACA, states must alter Medicaid eligibility rules and private insurance regulations to comply with the law and must establish individual and small business insurance exchanges. The latter requires oversight, risk adjustment, coordination of eligibility determination, and standardization and centralization of information about plans available in the exchanges. Additionally, states have the option to bid on numerous federal grants and demonstration projects outlined in the law, including bundled payment pilots, medical home pilots, and wellness initiatives. Coordinating these various projects, however, will demand time and resources that states may not have in the wake of the recession and consequent budget cuts.⁴³

The federal and state governments jointly fund Medicaid, the relative contributions of each depending on state per-capita income. (The average federal contribution is 57% but ranges from 50%–76%.) To minimize the financial burden to the states of expanded Medicaid coverage, the federal government will pay 100% of Medicaid expenses for newly eligible individuals from 2014 to 2016 and will gradually lower its contribution to 90% in 2020 and thereafter. The federal government will also cover 100% of Medicaid reimbursement increases scheduled for 2013 and 2014. Despite this federal assistance, state governments will also need to increase Medicaid expenditures. A simulation by the Kaiser Commission on Medicaid and the Uninsured found that if 57% of newly eligible individuals enroll, state spending on Medicaid will grow 1.4% between 2014 and 2019. The spending increase will be greater, however, for states like Texas (3.0% increase in Medicaid spending) or Alabama (3.6% increase) that currently have low Medicaid coverage and will absorb larger numbers of new eligibles in 2014 than for states like Massachusetts (2.1% *decrease*) or New York (no change) that already provide high levels of coverage.⁴⁴ Since state governments, unlike the federal government, cannot run deficits, mandated higher Medicaid spending requires cuts in services elsewhere, which is particularly challenging during a recession, when tax revenues decline.⁴⁵

How will reform affect insurance companies? The individual and small-group insurance markets will gain approximately 15 million new members after the individual mandate goes into effect in 2014. Commercial insurers will need to report medical loss ratios beginning in 2010 and pay rebates to consumers in 2011 for administrative costs and profits above established thresholds. The medical loss ratio benchmark for individual and small-group payers (80%) is lower than that for large-group payers (85%) because the former market uses insurance brokers who are paid on commission, sometimes up to 30% of the first year's premium. Many large insurers currently fail to meet the federal medical loss ratio benchmarks.⁴⁶ The law will result in reduced payments to insurance brokers and possibly their gradual disappearance, particularly since individuals and small businesses will be able to buy coverage directly through exchanges.⁴⁷ Finally, as Massachusetts has done,⁴⁸ states will begin reviewing and approving proposed premium increases.

How will reform affect providers? The PPACA includes financial incentives and expanded training opportunities for PCPs. Nonetheless, experts worry that the health system lacks capacity to absorb the 32 million people expected to gain coverage under the PPACA, particularly the 16 million who will join Medicaid and who may continue to receive care from the safety-net hospitals and community health centers that have historically cared for low-income individuals. While increased Medicaid payments may increase the number of primary care providers that accept Medicaid patients, the lack of corresponding incentives for specialists may mean that demand for specialty care by the newly insured exceeds supply.⁴⁹ Even in Massachusetts, where the ratio of

physicians per person is relatively high, the expansion of coverage has been associated with a shortage of primary care physicians.⁵⁰

Additionally, many experts worry that cost-containment efforts within Medicare will widen the gap in reimbursement rates between commercial payers and Medicare and will therefore prompt providers not to accept Medicare beneficiaries.^{51,52,53} Eventually, the government may need to regulate reimbursement rates of both public and private insurers.

Finally, providers will have new payment incentives to improve quality and reduce errors, infections, and hospital readmissions and may participate in pilot projects (e.g., bundled payments, medical homes,⁵⁴ accountable care organizations, etc.) designed to improve quality and reduce cost. These demonstration projects will likely come with financial risk but also possible financial gain for providers.

Part I: 2009

Sally Sullivan is a 51-year-old florist who lives with her husband, Warren, age 53, and her son, Dirk, age 22, in Tyler, Texas. The family lives on Sally's income and disability payments from the Social Security Administration, which began seven years ago after Warren was blinded in an accident involving chemicals at the small paper mill where he worked. (The mill has since closed.) With these combined incomes, the family makes approximately \$46,000 before taxes. Dirk has worked on and off since high school and is contemplating applying to community college.

The family obtains health insurance through Sally's employer, Fran's Flowers, which offers coverage for employees through Texas's small-group market. Sally purchases family coverage with a monthly premium of \$1,540, of which Fran contributes half. (This premium cost is above the national average for employer-sponsored coverage⁵⁵ but close to average for the East Texas small-business insurance market.⁵⁶) Sally remarks to a friend that she can't believe that the family's premium cost has doubled in the past eight years, both because the total premium has risen and because Fran's Flowers has slowly lowered its contribution to the premium from 75% to 50%. (Nationwide, employers cover an average of 73% of premiums for family coverage;⁵⁷ since Fran's Flowers is a small business and is struggling financially, it covers a smaller portion than the average employer.)

With a monthly family premium contribution of \$770, health insurance consumes 20% of the Sullivan family's pretax income. Sally keeps the insurance, however, because four years ago doctors discovered a cyst in Warren's brain that did not require immediate intervention but that might require surgery in the future. Without insurance, the family would never be able to afford the cost of surgery.

Medicaid eligibility for working parents in Texas is 26% FPL,⁵⁸ at 250% FPL and with a grown son, the Sullivans don't qualify. Moreover, at present the family's insurer only covers nonstudent dependents up to the age of 22, meaning that Dirk will lose insurance coverage when he turns 23. Fortunately, he appears to be in fine health.

Discussion Questions

- Insurance premiums in Texas nearly doubled in the eight years between 2000 and 2007.⁵⁹ What determines the price of insurance premiums? Why is coverage in the individual and small-group markets more expensive than coverage in the large-group market? What are some of the factors that drive the growth of premiums? What effects, if any, will national health reform legislation have on premiums?
- Some groups have advocated for a nationwide move to single-payer health care. What are the pros and cons of employer-based insurance and state-sponsored insurance? Why do you think the PPACA keeps the current system of employer-based insurance?

Part II: 2010

Dirk, who has just turned 23, is uninsured when President Obama signs the PPACA into law. Sally muses that he has just “missed the boat,” since dependent coverage up to age 26 does not become mandatory until 2014, when Dirk will turn 27. Two weeks later, however, the family receives a letter from the insurance company explaining that the company is voluntarily expanding dependent coverage early, with forms included for enrolling dependents between the ages of 23 and 26.

Discussion Questions

- Dirk won't be subject to the individual mandate until 2014. Since they're able to, should the family add him back onto their insurance plan now? What are some possible consequences if they do and if they don't?

Part III: 2011

After more than three years of economic troubles, Fran's Flowers decides it has no choice but to stop offering health insurance in order to remain solvent. Sally knows that buying insurance in the individual market will be essentially impossible due to Warren's cyst, which insurance companies will treat as a preexisting condition. (Preexisting condition exclusions for adults will not be outlawed until 2014.)

Fortunately, the state's new high-risk pool is now operational and offers plans with more affordable premiums (\$800/month) than the previous high-risk pool (over \$1,000/month). The Sullivans enroll Warren in the high-risk pool. Sally, feeling that she is too old to go without insurance, buys the cheapest plan available on the Texas individual market, which, for a 53-year-old woman, has an annual premium of \$5,000. The family now spends a total of \$14,600, over 30% of pretax income, on health insurance.

Part IV: 2014

The high-risk pool terminates, and the Texas Health Benefit Exchange opens for enrollment. Still close to 250% FPL, the Sullivans are eligible for tax credits that would reduce their premium to 8.05% of income, assuming they purchased the second-cheapest “silver plan” in the Texas exchange. Sally and Warren explore coverage options through the state exchange’s website, linked from www.healthcare.gov. Sally does the math and decides that, given Warren’s routine visits to the neurologist and the possibility of surgery, they are better off purchasing a more expensive but more generous “gold plan.” Still, Sally is relieved to see the family’s health costs fall so dramatically, which will allow her to put aside a greater portion of income for retirement. Meanwhile, Dirk, now 27, has recently married, and his wife’s employer provides coverage for the couple. They opt for a catastrophic policy.

Discussion Questions

- What are the pros and cons of catastrophic coverage?
- A number of state Attorneys General are contesting the constitutionality of the PPACA’s individual mandate in court. What are the consequences if judges rule in the Attorneys General’s favor and the individual mandate is overturned at the state or federal level?
- Many experts have expressed skepticism that Congress will approve the Medicare payment cuts that make the PPACA deficit reducing. What are the respective roles in cost containment of reforms such as reduced reimbursements to Medicare, elimination of fraud and waste in public programs, payment reform, comparative effectiveness research, and quality improvement? On what timescale can we expect to see results from these reforms? If the bill’s cost-containment provisions fail, what are some possible next measures for the government to take?

¹ Five Basic Facts on the Uninsured. Kaiser Family Foundation, 2009. (Accessed at <http://www.kff.org/uninsured/upload/7806-02.pdf>.)

² Hiebert-White J. 52 Uninsured Americans by 2010. Health Affairs Blog, 2009. (Accessed at <http://healthaffairs.org/blog/2009/06/02/52-million-uninsured-americans-by-2010/>.)

³ Schoen C, Collins SR, Kriss JL, Doty MM. How Many Are Underinsured? Trends Among U.S. Adults, 2003 And 2007. Health Affairs 2008;102:w298-w309.

⁴ Five Basic Facts on the Uninsured.

⁵ Schoen C, Nicholson JL, Rustgi SD. Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes. Commonwealth Fund, August 2009. (Accessed at http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf.)

⁶ OECD Health Data 2010. Organisation for Economic Co-operation and Development, 2010. (Accessed at http://www.oecd.org/document/11/0,3343,en_21571361_44315115_45549771_1_1_1_1,00.html.)

⁷ OECD Health Data 2010. Numbers given as dollars per capita, purchasing power parity.

⁸ Chernew ME, Hirth RA, Sonnad SS, Ermann R, Fendrick AM. Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence. Medical Care Research and Review 1998;55:259-288.

⁹ Newhouse JP. Assessing Health Reform’s Impact On Four Key Groups of Americans. Health Affairs 2010;29:9.

¹⁰ Chernew ME, Hirth RA, Cutler DM. Increased Spending on Health Care: Long-Term Implications For The Nation. Health Affairs 2009;28:1253-1255.

¹¹ Newhouse.

¹² Cortese D, Smoldt R. Taking Steps Toward Integration. Health Affairs 2007;26:w68-w71.

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- ¹³ Heading for the emergency room. *The Economist*. June 2009. .
- ¹⁴ Davis K, Schoen C, Stremikis K. Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update. Commonwealth Fund, 2010. (Accessed at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx>.)
- ¹⁵ McGlynn EA, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 2003;348:2635-2645.
- ¹⁶ Wennberg JE, Fisher ES, Goodman DC, Skinner JS. Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008. Lebanon, NH: Dartmouth Institute for Health Policy and Clinical Practice, 2008.
- ¹⁷ Cost Estimate to Speaker Nancy Pelosi, U.S. House of Representatives. Washington, D.C.: Congressional Budget Office, 2010. In: Weil A, Scheppach R. New Roles for States in Health Reform Implementation. *Health Affairs* 2010;29:1178-1182.
- ¹⁸ Summary of Coverage Provisions in the Patient Protection and Affordable Care Act. Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/healthreform/upload/8023-R.pdf>.)
- ¹⁹ Explaining Health Care Reform: Questions About the Extension of Dependent Coverage to Age 26. Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/healthreform/upload/8065.pdf>.)
- ²⁰ Lavelle J. State sets rates for new high-risk health care plan. *San Diego Union-Tribune*, 2010. (Accessed at <http://www.signonsandiego.com/news/2010/aug/05/state-sets-rates-for-new-high-risk-plan>.)
- ²¹ Patel K, McDonough J. From Massachusetts to 1600 Pennsylvania Avenue: Aboard the Health Reform Express. *Health Affairs* 2010; 29:1106-1111.
- ²² For a review of adverse selection theory, see Cutler DM, Zeckhauser RJ. Adverse Selection In Health Insurance. *Forum for Health Economics and Policy* 1998;1:Article 2.
- ²³ Newhouse.
- ²⁴ Summary of Coverage Provisions in the Patient Protection and Affordable Care Act.
- ²⁵ Health Care in Massachusetts: Key Indicators Report. Boston, MA: Division of Health Care Finance and Policy, 2010.
- ²⁶ Survey of People Who Purchase Their Own Insurance. Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>.)
- ²⁷ August 2010 HHS Poverty Guidelines. U.S. Department of Health & Human Services, 2010. (Accessed at <http://aspe.hhs.gov/poverty/10poverty.shtml>.)
- ²⁸ Medicaid and State Funded Coverage Income Eligibility Limits for Low-Income Adults, 2009. Kaiser Family Foundation, 2009. (Accessed at <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.)
- ²⁹ Income, Poverty, and Health Insurance Coverage in the United States: 2007. U.S. Census Bureau, 2008. (Accessed at <http://www.census.gov/prod/2008pubs/p60-235.pdf>.)
- ³⁰ Health Care Reform and the CLASS Act. Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/healthreform/upload/8069.pdf>.)
- ³¹ Jost T. Implementing Health Reform: The Web Portal and Early Retiree Reinsurance. *Health Affairs Blog*, 2010. (Accessed at <http://healthaffairs.org/blog/2010/05/05/implementing-health-reform-web-portals-and-retiree-reinsurance>.)
- ³² Jencks SF, Williams MV, Coleman EA. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine* 2009;360:1418-1428.
- ³³ Orszag PR, Emanuel EJ. Health Care Reform and Cost Control. *New England Journal of Medicine* 2010;363:601-603.
- ³⁴ Arvantes J. Provisions in Health Care Reform Law Lay Out Role of Primary Care, Family Physicians. *AAFP News Now*, 2010. (Accessed at <http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20100728hcreformoverview.html>.)
- ³⁵ CCH Editorial Staff. CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act. Volume 1. Wolters Kluwer, 2010.
- ³⁶ Orszag and Emanuel.

-
- ³⁷ Berenson RA. Implementing Health Reform—Why Medicare Matters. *New England Journal of Medicine* 2010;363:101-103.
- ³⁸ Jost T. The Independent Payment Advisory Board. *New England Journal of Medicine* 2010;363:103-110.
- ³⁹ Orszag and Emanuel.
- ⁴⁰ Summary of New Health Reform Law. Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/healthreform/upload/8061.pdf>.)
- ⁴¹ *Ibid.*
- ⁴² Cassidy A, Dentzer S. Health Policy Brief: Near-Term Changes In Health Insurance. *Health Affairs*, 2010. (Accessed at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=16.)
- ⁴³ Weil and Scheppach.
- ⁴⁴ Holaham J, Headen I. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2010. (Accessed at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>.)
- ⁴⁵ Newhouse.
- ⁴⁶ Schoofs M, Johnson A. Health Overhaul Hits Sales Commissions. *Wall Street Journal*. May 18, 2010. B1.
- ⁴⁷ Newhouse.
- ⁴⁸ Wallack T, Lazar K. Blue Cross agrees to reduce rate increase. *Boston Globe*. August 6, 2010.
- ⁴⁹ Newhouse.
- ⁵⁰ Access to primary care physicians getting tougher, report finds. *Boston Globe*. July 26, 2010.
- ⁵¹ Jost. The Independent Payment Advisory Board.
- ⁵² Berenson.
- ⁵³ Newhouse.
- ⁵⁴ Patient-Centered Medical Home. American College of Physicians. (Accessed at http://www.acponline.org/running_practice/pcmh/.)
- ⁵⁵ Employer Health Benefits: 2008 Summary of Findings. Kaiser Family Foundation, 2008. (Accessed at <http://ehbs.kff.org/images/abstract/7791.pdf>.)
- ⁵⁶ Small Employer Health Benefit Plan Rate Guide – Tyler. Texas Department of Insurance. (Accessed 2010, at <http://www.tdi.state.tx.us/pubs/consumer/sergctyler.html>.)
- ⁵⁷ Employer Health Benefits: 2008 Summary of Findings.
- ⁵⁸ Texas: Medicaid/CHIP Eligibility. Kaiser Family Foundation. (Accessed at <http://www.statehealthfacts.org/profileind.jsp?rep=43&cat=17&rgn=45>.)
- ⁵⁹ *Premiums Versus Paychecks: A Growing Burden for Texas's Workers*. Families USA, 2008. (Accessed at <http://www.familiesusa.org/assets/pdfs/premiums-vs-paychecks-2008/texas.pdf>.)