BENEFITS AND COSTS OF THE HEALTH CARE REFORM BILL

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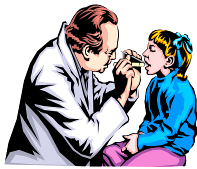
Recently-passed health care legislation is, in effect, only the starting point for reform of our health system. Ten years from now, the reforms in place may bear only a passing resemblance to those enacted this year. Areas where further change is likely, needed or both are pointed out after this discussion of the costs and benefits of the Patient Protection and Affordable Care Act (PPAC).

What are the major provisions benefiting consumers in the health care reform bill?

- The Patient Protection and Affordable Care Act imposes new regulations on the insurance industry regarding pre-existing conditions, annual and lifetime payout limits, required coverage and the pricing of premiums.

Details: Starting in 2010, insurers must cover children with pre-existing conditions and are prohibited from arbitrarily dropping persons from coverage. They must also provide dependent coverage until age 26 and plans must include free coverage of certain recommended preventive services and screenings. From 2010 to 2014, there will be a national program to provide coverage to persons with pre-existing conditions via a high-risk pool.



By 2014, all insurers will be prohibited from denying coverage due to pre-existing conditions, and annual and lifetime limits on benefits will also be prohibited. Certain basic benefits will also be required. Also, by 2014, premiums may take into account age, tobacco use, geography, family composition, and participation in a health promotion program but not health status. Large-group health plans will be required to refund enrollees for premiums spent on items other than medical care, once those expenditures exceed 15% of the total (starting in 2011). For small-group plans, the percentage will be 20%.

- PPAC increases the percentage of persons with health care by requiring states to set up Insurance Exchanges, by providing subsidies for insurance premiums, by providing tax credits for employers, and by expanding coverage under Medicaid.

Details: Effective 1/1/14, states will have set up Insurance Exchanges, through which individuals and small businesses with up to 100 employees can purchase qualified coverage from insurers. (This can be extended to larger firms starting in 2017, if a state so chooses.) States will oversee these Exchanges, and subsidies will be available – paid to insurers through the Internal Revenue Service. See Note 1 below for details about subsidy levels and tiers of coverage.[1]

Employees who are offered coverage by an employer cannot participate in an Exchange plan *unless* the employer plan offers inadequate coverage (as defined) or unless the employee share of the premium exceeds 9.5% of income. Qualifying employees are eligible for premium tax credits.

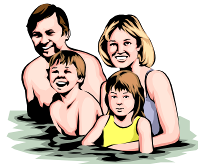
Medicaid will be available to eligible individuals under age 65 (children, pregnant women, parents and adults without dependent children) with incomes up to 133% of the federal poverty level (undocumented immigrants are excluded).

- The Mississippi Health Advocacy Program estimates that over 300,000 persons in Mississippi who would have been uninsured will have access to health insurance as a result of these reforms. The U.S. Department of Human Services has similar figures.[2] Nationally, by 2019 about 94% of the nonelderly popu-

lation (excluding undocumented immigrants) will be covered by insurance, compared to 83% currently. There will be 32 million persons covered who otherwise would have lacked insurance; at the same time, 23 million persons will remain uninsured, according to Congressional Budget Office (CBO) estimates (3/10).

Who is paying what to cover the cost of this expanded health care coverage?

- There are several sources of finance, depending on who the newly-covered individuals are. Some parents will be keeping children on their policies for a bit longer (up to age 26) – in this case, the families and their employers will be paying the bulk of the cost. The federal government (i.e. taxpayers) will be paying the full cost of families newly- eligible for **Medicaid** initially, with a state contribution gradually phasing in.



  Low-income individuals will eventually be required to purchase health care coverage, but the cost will be heavily subsidized -- so, both the individuals covered and taxpayers will be paying.

- And in yet other cases, individuals and firms will buy health care insurance through **insurance Exchanges**, in some cases paying the full premiums themselves, but in other cases premiums will be subsidized. Some gaps in current coverage will be closed: insurance plans will be required to offer coverage in instances where they did not before, and the infamous "donut-hole", which requires seniors on Medicare to fully fund their prescription drug purchases in some cases, will be closed gradually.

- Federal and state subsidies will be financed through a variety of revenue sources. In addition, the cost of health care will be reduced via several measures, as explained below.

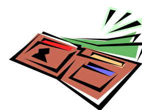
So, what are the new taxes on individuals?

- The bulk of new taxes are on businesses, but there are some tax increases for individuals. Starting in 2013, the Medicare Hospital Insurance tax, which is a part of payroll taxes, will be increased by 0.9% for individuals with adjusted gross incomes over $200,000; these taxpayers will also be subject to a 3.8% Medicare tax on investment income (including capital gains). There will be a limit of $2,500 on flexible spending arrangements in employee "cafeteria" plans in 2013, which will be indexed to inflation (as measured by the consumer price index). The threshold to deduct medical expenses will be raised to 10% of adjusted income in 2013.

- Under the **individual mandate**, which requires most individuals to have health insurance coverage, those not in compliance will be subject to a penalty, phased in at 1% of income or a maximum of $95 in 2014, but rising to 2.5% of income or a maximum of $695 by 2016 for those with incomes at or above 400% of the poverty level. There will be a hardship exemption.[3]

On employers?

- Employers with more than 50 fulltime employees must provide health insurance coverage with essential benefits or pay a **penalty**. The basic penalty will be $2,000 per fulltime equivalent employee (with the first 30 workers exempted). There will also be a penalty if any full-time employee receives a premium subsidy on insurance purchased through the Exchange ($3,000 per employee receiving a premium credit excluding the first 30 employees). Smaller firms will not face penalties. There will be tax credits for firms with fewer than 25 employees and for tax-exempt organizations. (Effective 2014.)



  Larger firms, with more than 200 employees, must enroll employees into employer health insurance plans.

On firms more generally?
Various tax benefits are reduced and tax loopholes closed; new taxes on health-related firms are imposed.[4]

Some of the major changes are:

- An annual fee on large **pharmaceutical manufacturers** will yield about $27 billion by 2019. There will also be an excise tax on sales of medical device manufacturers beginning in 2013 that will bring in $20 billion over 2013-2019. Firms and other entities paying corporations will be required to report those payments to the IRS beginning in 2012. $17 billion is expected.

- **Insurers** will pay an annual fee, based on market share, starting in 2014. A yield of $60 billion is predicted over 2014-2019. Insurers will also face a 40% excise tax on high-cost insurance plans starting in 2018. A high-cost plan is one with premiums in excess of $10,200 for individuals or $27,500 for families in 2018, but indexed to inflation. Over $12 billion is expected annually from this tax, whose purpose is to encourage more cost-efficiency in the provision of health services.

- In addition to these new fees, there are several smaller new revenue sources. Transactions undertaken by firms primarily to avoid taxes are now subject to the **economic substance doctrine**, as laid out in the health reform legislation. If a transaction lacks economic substance, and the firm is found to have underpaid taxes owed, there will be a penalty. Over $4 billion is expected from this provision over the coming decade. A 10% tax on indoor tanning services starting July 1 is expected to bring in over $2 billion over 2010-2019. Reductions in the biofuel producer credit for certain waste by-products will bring in about $24 billion by 2019.

And, just as importantly, how are costs being reduced?
About $545 billion is expected to be saved by provisions that result in reduced federal expenditures on health care from 2010-2019. The CBO estimates that these savings will be more important in financing the reforms than are increased taxes and fees, which in contrast are expected to bring in a net $525 billion.

Reductions will be made in federal payments to some private insurers under Medicare Advantage. Currently the government is paying private insurers more on average for offering seniors the same coverage as Medicare, and this gap will be gradually eliminated. $136 billion in savings is projected by CBO.

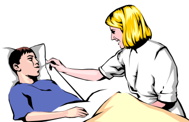
More significant, and more hotly-contested, is the provision for reducing the rate of increase in Medicare payments as productivity growth reduces costs. In 2019, over $40 billion is expected to be saved as a result of this **productivity provision** – and $157 billion over the 2010-2019 period. See accompanying article on health care costs for more details.

The CBO notes that increases in payment rates for many providers would be held below the rate of inflation, in expectation of ongoing productivity improvements in the delivery of health care. But it warns that "It is unclear whether such a reduction in the growth rate of spending…..would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care."

Any closing thoughts on the future of health care reform?
Individuals who are newly-covered by an insurance plan as a result of PPAC, and those newly-eligible for treatment of pre-existing conditions, stand to benefit substantially from health reform.

But, as in Massachusetts where similar legislation has been in effect since 2006, the problem of rising costs, and so rising premiums, is likely to be a major hurdle for the reform effort.[5] In addition, successful implementation will require the development of new areas of expertise in the states. States are charged with enforcing many of the new regulations, and with establishing and overseeing insurance Exchanges. Some states are better-equipped to handle this challenge than others. Several states have already set up high-risk pools and have experience in the area (although results of these efforts have been mixed). Medicaid matching funds must also be found, a challenge that may involve an overhaul of state tax systems.

A strong commitment to the health of its citizens will be necessary for the states, and the nation, to negotiate the twists and turns that lie ahead. Modifications to the new legislation are inevitable, but the experience gained through concentrated efforts to expand coverage and control costs will be valuable in achieving much-needed improvements in the health care system.



Notes

1. Subsidies will be given to individuals and families who purchase insurance through Exchanges that will be set up so that the contributions they make are limited to at most:

2% of income, if income is at or below 133% of federal poverty level (FPL);
3 - 4% of income, for incomes 133 – 150% FPL;
4 – 6.3% of income, for incomes 150 – 200% FPL ;
6.3 – 8.05% of income, for incomes 200 – 250% FPL;
8.05% - 9.5% of income, for incomes 250 – 300% FPL;
9.5% of income, for incomes 300 – 400% FPL.

(The Federal Poverty Level is $22,000 for a family of four.) Funding will be available to the states to establish these exchanges until January 1, 2015.

Plans available through Exchanges can be set up to cover 70%, 80%, or 90% of costs that are expected actuarially, with the higher coverage costing more. (This is the oft-discussed tier system.) Persons under 30 years of age, and persons for whom coverage would absorb more than 8% of income, also have the choice of purchasing catastrophic coverage only.

2. U.S. Department of Health and Human Services.
http://www.healthreform.gov/reports/statehealthreform/mississippi.html

3. Most individuals who lack health insurance coverage will be required to purchase health insurance, or pay a fine by 2014. The major exceptions are Native Americans, those for whom the required premium would be a financial hardship, and poor undocumented immigrants who are not eligible for subsidized health coverage (even if they meet the income requirements for Medicaid coverage).

Individuals at or below 133% of the federal poverty level will be eligible for a version of Medicaid with certain 'benchmark' benefits, starting in 2014. There will initially be federal funding to assist states with the increased costs that result.

Persons who are between 133% and 400% of the federal poverty level will receive subsidies to help finance their health care premiums.

A problem bears mentioning here: there seems to be no easy way to stop individuals from signing up for coverage when faced with the need for costly medical treatment and then dropping coverage immediately afterward.

4. See www.commonwealthfund.org, "Timeline for Health Care Reform Implementation: Revenue Provisions" for a complete listing of tax changes.

5. The experience of Massachusetts shows some of the problems that lie ahead for cost containment. The New York Times (4/21/10), in an editorial entitled "Reform and Massachusetts", states that two-thirds of Massachusetts voters told pollsters that they supported the state's health reforms. These reforms included an expansion of Medicaid, which requires matching funds from the state – and the current budget squeeze makes meeting this bill difficult. Insurers have requested premium increases that were largely rejected by regulators, but costs must be controlled if insurers are to continue to meet minimum coverage requirements. The fee-for-service system, in which doctors and hospitals are paid for the volume of care they provide whether or not it is high quality or needed, is under attack. There is talk of 'bundling' services so that one fee covers whatever care a patient needs over the course of a year. Greater regulation of provider payments is also being discussed. The apparent consensus is that the incentive to rein in costs has increased, now that about 97% of residents are enrolled in a health care plan.

Sources

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