The Impact of Health Care Reform on Kentucky Health

Foci

- What values to be maximized?
- Who gets care and for what reasons?
- Who are key financiers?
- Who gets paid for providing care?
- How does KY compare?
- How does the recent reform legislation reflect competing/complementary values?
- What outcomes for KY if the legislation implemented? Who wins and who loses?

Three Laws of Clinical Care Reform in Rich Democracies

- No matter how good the health care in a particular country, people will complain about it.
- No matter how much money is spent on health care, the doctors and hospitals will argue that it is not enough.
- The last reform always failed.

Tsung-Mei Cheng, Healthcare Economist

The Perennial Questions

COST: Who pays for clinical care (how much)?

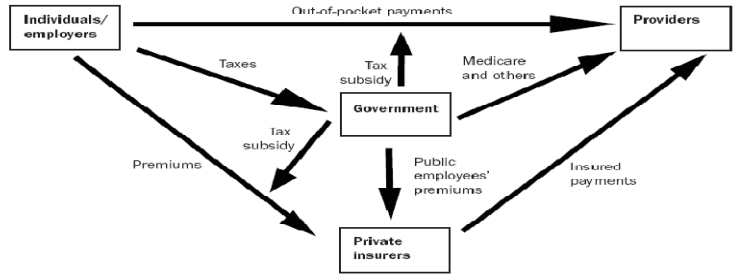
ACCESS & EQUITY: Who gets care (what kind, when, from whom)?

EFFICIENCY: Who gets paid (how much, for doing what)?

EFFECTIVENESS: How does what happens affect outcomes (improve health of individuals and populations)?

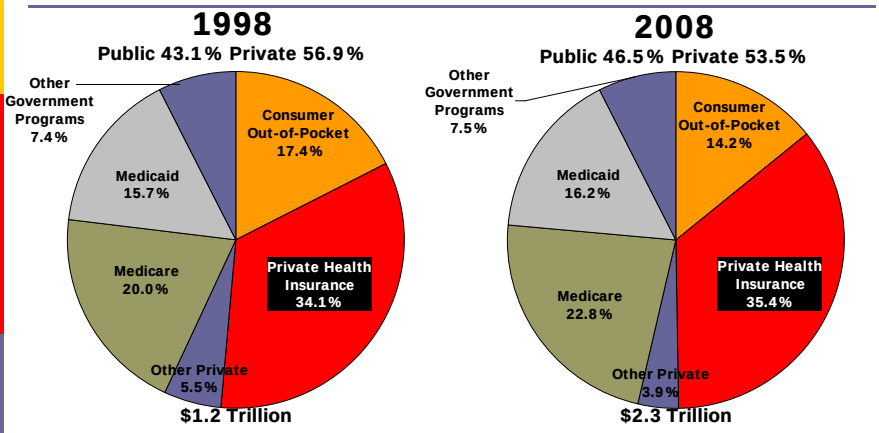
Health care financing

EXHIBIT 1
Flow Of Health Care Financing Funds Among Individuals/Employers, Providers, Government, And Private Insurers



SOURCE: Authors' analysis.

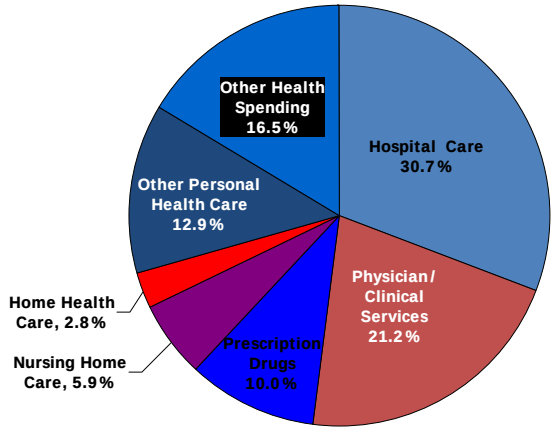
Distribution of Personal Health Care Spending by Source of Payment, 1998 and 2008



Notes: Personal health care expenditures excluding administration and net cost of insurance, public health activity, research, and structures and equipment. Out-of-pocket health insurance premiums paid by individuals are not included in Consumer Out-of-Pocket; they are counted as part of Private Health Insurance. Medicaid spending for the State Children's Health Insurance Program (which began in 1998) is included in Other Government Programs, not in Medicaid.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2008; file nhe2008.zip).

Distribution of National Health Expenditures, by Type of Service, 2008

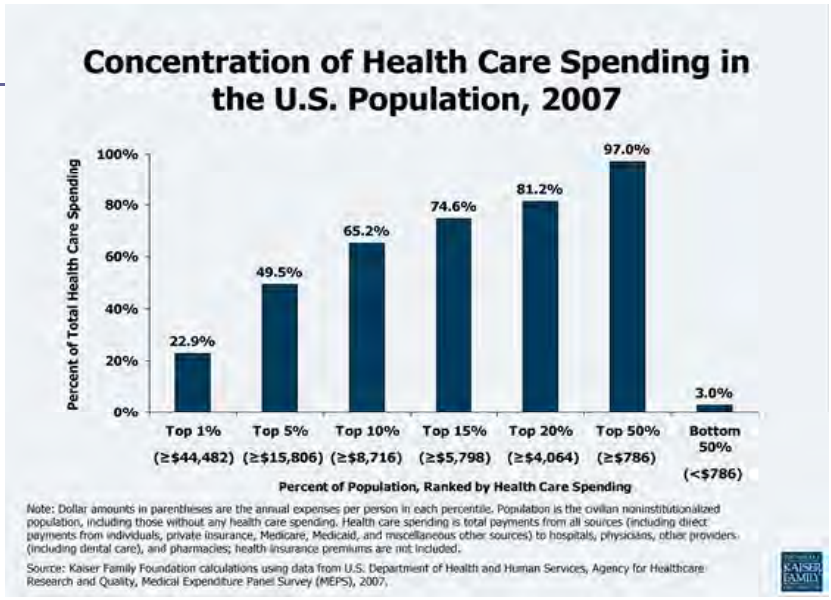


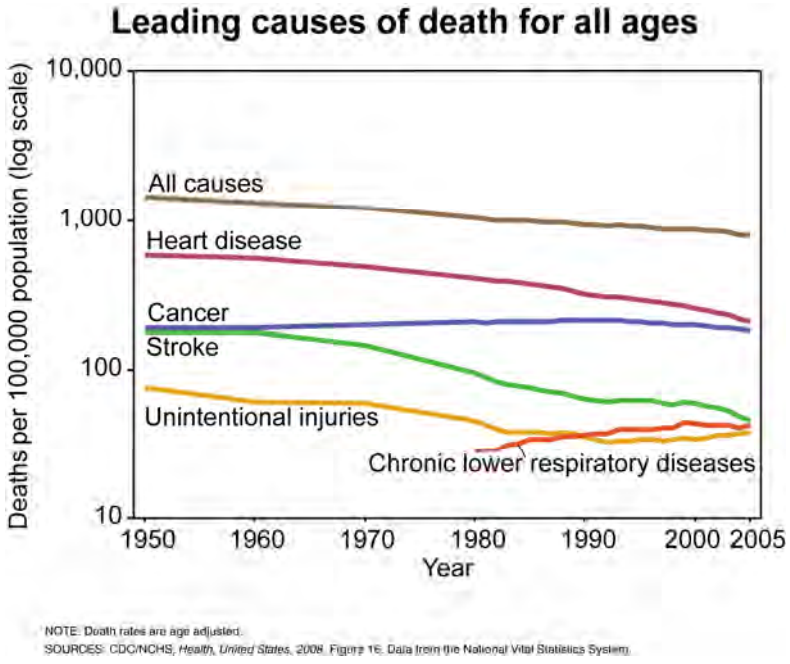
Note: Other Personal Health Care includes dental and other professional health services, durable medical equipment, etc. Other Health Spending includes administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2008; file nhe2008.zip).

Table 1.
Source of Increase in Private Health Expenditures, 2003-2008 By NHE Category

Private National Health Expenditure Categories[1]	% Share of Private Health Insurance Expenditures (2003)	% of Share of Private Health Insurance Expenditures (2008)	Source of Increase in Private Health Insurance Expenditures (2003-2008)
Hospitals	31%	34%	41%
Physicians and Clinical Services [2]	32%	34%	38%
Prescription Drugs	14%	12%	8%
Private Administration and Net Cost of Insurance	14%	12%	7%
Dental	6%	6%	5%
Other Health Categories	3%	2%	1%


Concentration of Health Care Spending in the U.S. Population, 2007
Percent of Total Health Care Spending
100%
80%
60%
40%
20%
0%
22.9%
49.5%
65.2%
74.6%
81.2%
97.0%
3.0%
Top 1% (≥$44,482)
Top 5% (≥$15,806)
Top 10% (≥$8,716)
Top 15% (≥$5,798)
Top 20% (≥$4,064)
Top 50% (≥$786)
Bottom 50% (<$786)
Percent of Population, Ranked by Health Care Spending
Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.
Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2007.


Leading causes of death for all ages
Deaths per 100,000 population (log scale)
10,000
1,000
100
10
All causes
Heart disease
Cancer
Stroke
Unintentional injuries
Chronic lower respiratory diseases
1950
1960
1970
1980
1990
2000
2005
Year
NOTE: Death rates are age adjusted.
SOURCES: CDC/NCHS, Health, United States, 2008, Figure 16. Data from the National Vital Statistics System.

Kentucky versus the U.S.

Death rates by cause/100K	
All deaths	898 v. 760
Cancers	225 v. 192
Cardiovascular	332 v. 288
Premature Death (yrs lost)	8929 v. 7511
Incidence of illnesses/Problem in Percent of population reporting	
Smoker	25% v. 18%
Obesity	30% v. 27%
Disability	20% v. 13%
Diabetes	10% v. 8%
Asthma	9% v. 8%
Frequent Mental distress	14% v. 9%
Cardiac Heart Disease	6% v. 4%
High Blood Pressure	30% v. 28%
Fair or poor health	20% v. 14%
Per Capita Personal Income	$32K v. $40K

Source: United Health Foundation Rankings 2009 www.americashealthrankings.org

Kentucky versus the U.S.

- Higher in disabled (26% v 15%) who spend 30% of income on health care
- Higher in pre-term and teen birth rates
- Higher in Medicaid (16% v 14%)
- Higher in Medicare (14% v 12%) where 33% are eligible for Part D subsidy b/c of low income & 30% hit donut hole
- higher in poor (22% v 18%)
- Higher in rural (50% v 16%)
- Higher in Rx/year (16 v 10)

KY v US: Methods of Coverage

In comparing the population of KY with the entire population of the United States

Fewer covered by employer (50% v 52%)

Fewer covered by individual (4% v 5%)

More covered by Medicare (14% v 12%)

More covered by Medicaid (16% v 14%)

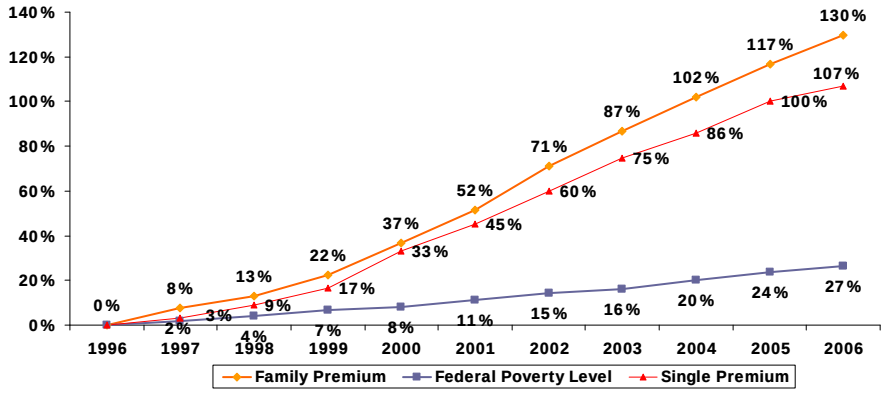
More covered by other public (4% v 3%)

Same uninsured (15% v 15%)

U.S. Employer Sponsored

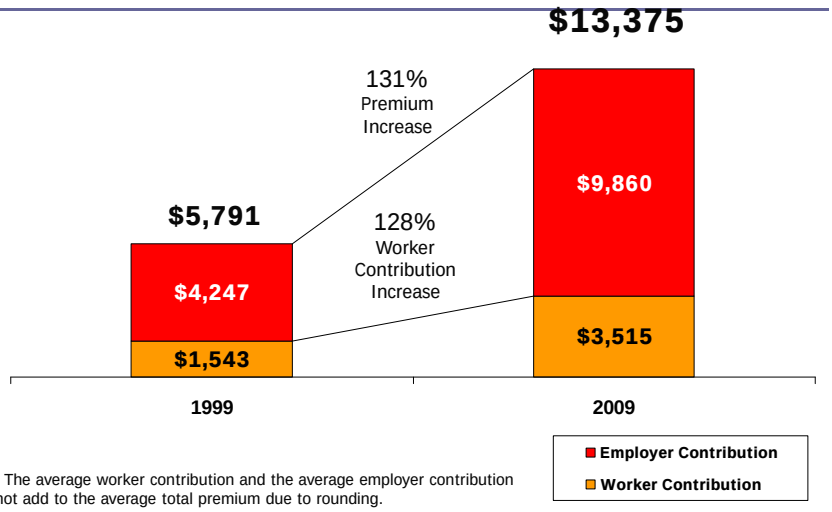
- Voluntary by employer
- 52% of population [159 M]
- $750 B (2009 est.)
- Paid by employers & employees
- Healthiest population & best svcs

Cumulative Change in Single and Family Health Insurance Premiums and Federal Poverty Level, 1996-2006



Source: Premium data from Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1996-2006, at http://www.meps.ahrq.gov/mepsweb/. Federal Poverty Level based on HHS Federal Poverty Guidelines (1996 through 2006) at http://aspe.hhs.gov/poverty/figures-fed-reg.shtml; rate of growth based on change for one person (change for a four-person family would be 28% rather than 27% over the period).

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

KY Average Premium Costs

2009 Employer Sponsored Group

- Family $12,231 with 25% employee contribution ($4,058 or $338/month)
- Individual $4,264 with 20% employee contribution ($852 or $71/month)

- Unemployment rate Dec. 09 10.7%

Source: Families USA

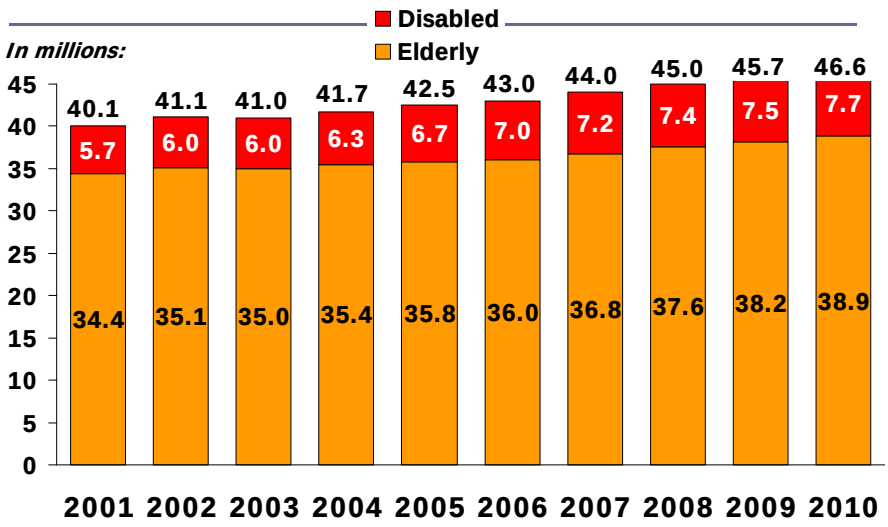
Individual Private Plans

- 6% of population [4M]
- $10 B
- market regulated uniquely in each state
- KY less than average

Medicare

- 14% of population [47 M]
- $475 B/year (2009)
- 39 M seniors; 8 M very disabled & 44% with 3+ chronic conditions.
- Part A payroll taxes, Parts B & C general taxes & some premium.
- Less generous than large employer plan.
- National government pays most.

Medicare Enrollment, by Eligibility Status, 2001-2010



SOURCE: Kaiser Family Foundation, 2001-2007: based on Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2002-2008; 2008-2010: Department of Health and Human Services, FY2010 Budget in Brief, May 2009.

Medicaid

- 19% of population [59 M]
- $356 B/year (2009 est)
- 30 M poor children, 8 M disabled, 6.1 M seniors, 15M adults. Includes SCHIP
- 40% of long-term care coverage.
- Fed/State cost share with 50-76% by fed through general taxes

Kentucky versus the U.S.

$4.6B 2007 11% of State General Fund v 17% of U.S. General Fund

- KY more on nursing home care
- KY more on kids ($2074 v $1708)
- KY more on adults ($3479 v. $2149)
- KY less on elderly ($8841 v $10,691)
- KY less on disabled ($8661 v 12,879)

Other Public Programs

3% of population [10M]

$30B

Includes TRICARE [1 M], VA [7.5M], IPHS [1M], DOD [.5M]

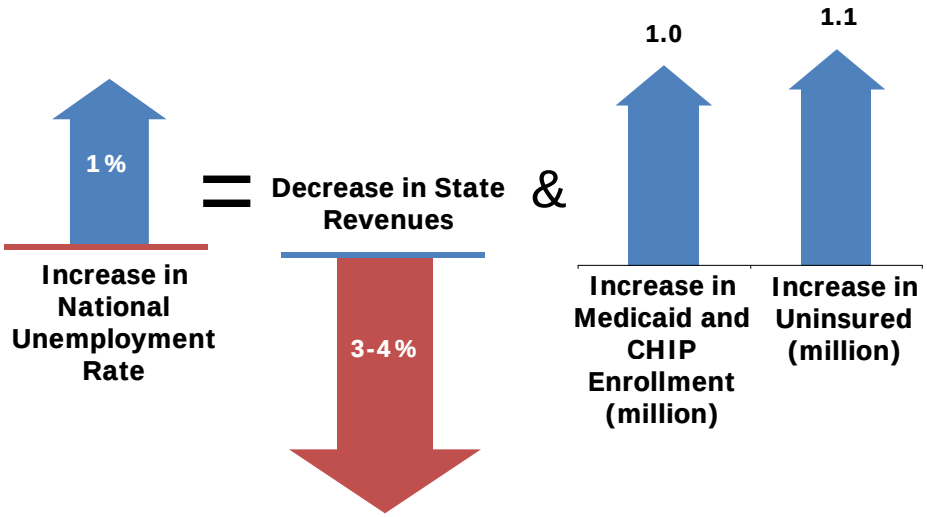
No Program [Uninsured]

16% of population: 49 M (2009 est.) with no coverage

- >60% uninsured full-time/full year wkrs in sm business and service
- All out-of-pocket payment
- In 2008 in KY, $450M of uncompensated care from hospitals, doctors for uninsured cost shifted to insured [CBO]
- Harms productivity of workers and hinders small business growth

Source: Families USA

Impact of a 1% Point Increase in Unemployment on State Revenues, Medicaid, CHIP & Uninsured



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

Some Impacts of Reform

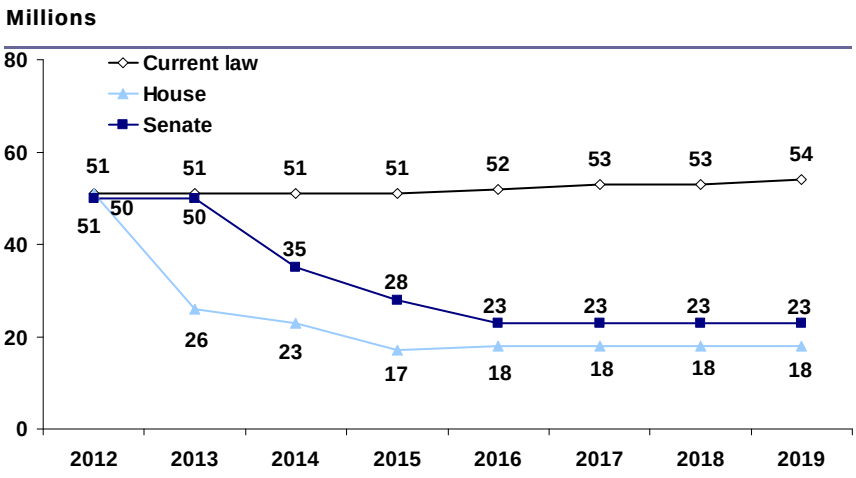
- Under Hs bill (AHCAA), ½ of current uncovered would be covered by 2013 and ¾ by 2019 (600K now uninsured)
- Significant decrease in number of medically induced or implicated bankruptcies [in KY in 2009, reduction of about 25,000 Chapter 7 and 13 bankruptcies filed]
- Most costs of increased coverage born by natl govt – about 70%. Shift cost to all txpyrs not just KY

Exhibit ES-1. Congressional Health

	House of Representatives 11/7/09	Senate 12/24/09
Insurance market regulations	GI, adjusted CR 2:1; in 2010: meet 85% medical loss ratio; uninsured eligible for high-risk pools, no annual or lifetime limits or rescissions, dependent coverage to 27	GI, adjusted CR 3:1; in 2011: health plans required to refund enrollees for non-claims costs >15% in large group market and >20% in small group & individual markets; uninsured eligible for high risk pools; no annual or lifetime limits or rescissions, dependent coverage to 26
Individual mandate	Penalty: 2.5% of the difference between MAGI and the tax filing threshold up to the average national premium of the "basic" benefit package	Penalty: Greater of $750/year per adult in household or 2% of income in 2016 phased in at $95 in 2014, $495 in 2015, $750 in 2016, up to a cap of national average bronze plan premium; family penalty capped at $2,250; exempts premiums >8% of income
Exchange	National or state	Regional, state, or substate
Plans offered	Private, public, and co-op	Private and co-op; multistate plans with at least one nonprofit plan, supervised by OPM
Eligibility for exchange	Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015	Individuals and small businesses 50–100, 100 by 2015, 100+ at state option
Essential benefit standard	Essential health benefits 70%–95% actuarial value, four tiers	Essential health benefits 60%–90% actuarial value, Four tiers; catastrophic policy for young adults <30 and those exempt from individual mandate
Premium/cost-sharing assistance	Sliding scale 1.5%–12% of income up to 400% FPL; cost-sharing credits 133%–350% FPL	Sliding scale 2%–9.8% of income up to 300% FPL/ flat cap at 9.8% 300%–400% FPL; cost-sharing subsidies for 100%–200% FPL
Medicaid/CHIP expansion	Up to 150% FPL	Up to 133% FPL
Shared responsibility/ Employer pay-or-play	Play or pay; firms >$500,000 payroll 72.5% + prem. contribution for indiv./65% + for families; sliding scale phased-in from 2% to 8% of payroll at $750,000; small employer tax credit; young adults can stay on parent's health plan to age 27	Firms >50 FTEs pay uncovered worker fee of $750; small employer tax credit; young adults can stay on parent's health plan to age 26

Note: GI = guaranteed issue; CR = community rating. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of proposals.

Senate Bills



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% and 96% of legal nonelderly residents are projected to have insurance under the Senate and House proposals, respectively.
Data: Estimates by The Congressional Budget Office.

Bills as of December 2009

	House of Representatives 11/7/09	Senate 12/24/09
Insurance market regulations	GI, adjusted CR 2:1; in 2010: meet 85% medical loss ratio; uninsured eligible for high-risk pools, no annual or lifetime limits or rescissions, dependent coverage to 27	GI, adjusted CR 3:1; in 2011: health plans required to refund enrollees for non-claims costs >15% in large group market and >20% in small group & individual markets; uninsured eligible for high risk pools; no annual or lifetime limits or rescissions, dependent coverage to 26
Individual mandate	Penalty: 2.5% of the difference between MAGI and the tax filing threshold up to the average national premium of the "basic" benefit package	Penalty: Greater of $750/year per adult in household or 2% of income in 2016 phased in at $95 in 2014, $495 in 2015, $750 in 2016, up to a cap of national average bronze plan premium; family penalty capped at $2,250; exempts premiums >8% of income
Exchange	National or state	Regional, state, or substate
Plans offered	Private, public, and co-op	Private and co-op; multistate plans with at least one nonprofit plan, supervised by OPM
Eligibility for exchange	Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015	Individuals and small businesses 50–100, 100 by 2015, 100+ at state option
Minimum benefit standard, tiers	Essential health benefits 70%–95% actuarial value, four tiers	Essential health benefits 60%–90% actuarial value, Four tiers; catastrophic policy for young adults <30 and those exempt from individual mandate
Premium/cost-sharing assistance	Sliding scale 1.5%–12% of income up to 400% FPL; cost-sharing credits 133%–350% FPL	Sliding scale 2%–9.8% of income up to 300% FPL/ flat cap at 9.8% 300%–400% FPL; cost-sharing subsidies for 100%–200% FPL
Medicaid/CHIP expansion	Up to 150% FPL	Up to 133% FPL
Shared responsibility/ Employer pay-or-play	Play or pay; firms >$500,000 payroll 72.5% + prem. contribution for indiv./65% + for families; sliding scale phased-in from 2% to 8% of payroll at $750,000; small employer tax credit; young adults can stay on parent's health plan to age 27	Firms >50 FTEs pay uncovered worker fee of $750; small employer tax credit; young adults can stay on parent's health plan to age 26

Note: GI = guaranteed issue; CR = community rating. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of proposals.

Reforms Shared by Senate & House Bills

- eliminate pre-existing & canceling practices – increase access
- Require citizens/legal residents to have insurance – increase access
- establish basic services covered for all and update periodically – increases equity
- expand Medicaid coverage to more of poor population – increases equity
- premium subsidies for poorer – increases access w/ advanced premium credit
- tax credit for SB who provide coverage – increases access
- temporary national reinsurance program for ERs who cover 55-64 retirees not eligible for Medicare –reduces premium costs for employers/employees with ESHI
- tax penalty for those who fail to get coverage –increases access & raises revenue
- limit max to FSA/HSA to $2500 – raises revenue, about $10B/yr
- create insurance exchanges – reduces premiums through broader risk pooling
- restrict abortion under insurance – minimal premium effect, may decrease outcomes
- restrict illegal immigrants from coverage – minimal premium effect, may decrease outcomes
- create 4 benefit levels with different deductibles applied to individual, small group, and exchange mkts only – decreases equity
- control out-of-pocket limits – increases equity. Increases cost about 1%
- eliminate maximum lifetime limits – increases equity. Increases cost about 1%
- allow some variation in costs of insurance – decreases access
- temporary national high risk pool – reduces premiums for employers and employees with ESHI
- requires standards for simplification – improves efficiency and lowers cost

Reforms Shared by Senate & House Bills

- Require employers to provide coverage if >50 ees or pay tax/fee
- Require employers to auto enroll ees in insurance plan (ee may opt out)
- increases age for dependent coverage – increases coverage of young
- allow for creation of trans-state insurance compacts – increases efficiency
- restructure payments for Medicare Medical Advantage plans – reduce costs
- 12 years of exclusive use of biologic drugs – protects Pharma
- authorize FDA to approve generic versions of biologic drugs after 12 years -- reduce costs over long run
- support comparative effectiveness research – increase effectiveness of treatments and perhaps reduce cost over long run and increases positive outcomes
- create primary care at home for certain, high need Medicare patients – increase effectiveness and reduces costs of re-hospitalization and increases positive outcomes
- require disclosure of financial relationships among providers – increase efficiency
- create national initiatives in health promotion/prevention/wellness – reduce costs over long run and increases positive outcomes
- Create national initiatives and evidence-based programs especially in underserved areas – access and effectiveness and increases positive outcomes
- chain restaurants and vending machines must have info disclosing nutritional content – reduce costs over long run and increases positive outcomes
- Health plans must report medical loss ratio [how much goes to pay claims] – increase efficiency
- Reduce certain Medicaid payments – reduce costs

Reforms Shared by Senate & House Bills

- Increase Medicaid drug rebate percentage – reduce cost
- create primary care at home for certain, high need Medicare patients – increase effectiveness
- require disclosure of financial relationships among providers – increase efficiency
- create national initiatives in health promotion/prevention/wellness – reduce costs over long run
- Create national initiatives and evidence-based programs especially in underserved areas – access and effectiveness
- chain restaurants and vending machines must have info disclosing nutritional content – increase effectiveness and reduce costs over the long run
- create Community living assistance services voluntary insurance program with auto enroll of all working adults – increase access and reduce costs
- Close donut-hole over time in Medicare – increase effectiveness and equity
- Establish scholarships and loans for medical trainees -- increase supply of providers to affect cost and efficiency
- Address nursing shortage – increase supply of providers to affect cost & efficiency
- create interdisciplinary training models to encourage integration of health care treatment and or primary care (medical home) models – increase effectiveness
- increase number and access to community heath centers – decrease costs.
- Work on reducing ethnic, racial, gender, language, disability status, and rural status disparities through various actions
- Create voluntary national long-term care insurance program with 5 yr vesting by payroll deduction with auto opt in provisions (ee may opt out)

Some cost/coverage issues

- House bill estimated cost is $894B (90B/year)
- Senate bill estimated cost is $871B (87B/year)
- financed thru savings from waste reduction in Medicare/Medicaid & new taxes/fees
- Senate largest single new source is excise tax on high-cost insurance
- House largest single new source is income tax surcharge (5.4%) on fam inc >$1M & individ >$500K
- Increase in demand if all uninsured covered est. at 2-3%

Key health care terms

■ **Employer health care tax credit:** An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe.

■ **Entitlement program:** Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation.

■ **Medicaid:** A federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines.

■ **Medicare:** A federal entitlement program that provides health insurance coverage to 45 million people, including people 65 and older, and younger people with permanent disabilities, end-stage renal disease and Lou Gehrig's disease.

■ **Medicare Advantage:** A health plan option under the Medicare program that allows participants to choose Medicare health maintenance organizations, preferred provider organizations, private fee-for-service plans or Medicare special-needs plans provided through private insurers.

■ **Pre-existing condition exclusions:** An illness or medical condition diagnosed or treated within a specified period of time before a person became insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed before the beginning of coverage.

■ **Public plan option:** A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly created health insurance exchange.

Patient Protection and Affordable Care Act: Summary of Coverage Provisions

The Patient Protection and Affordable Care Act was released on November 18, 2009 and was passed by the Senate on December 24, 2009. The following summary explains key health coverage provisions in the legislation.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $750 per person (up to a maximum of $2,250 per family), or 2% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; if the lowest cost health plan exceeds 8% of income; and if the individual has income below the poverty level ($10,830 for an individual and $22,050 for a family of four in 2009).

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009). This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a current limitation of the program that prohibits most adults without dependent children from enrolling in the program today. Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for three years (2014-2016). In 2017 and 2018, states will receive an increase in the federal medical assistance percentage (FMAP) based on current state eligibility levels for adults, and then beginning in 2019, all states will receive the same FMAP increase. Different funding rules apply for Nebraska and certain states that are not eligible for the increased FMAP because they have already expanded Medicaid eligibility.

American Health Benefit Exchanges

States will create the American Health Benefits Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants and subsidies will only be available to those without other coverage or whose share of the premium for coverage offered by an employer exceeds 9.8% of their income. Small businesses with up to 100 employees can purchase coverage through the Exchange.
- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.
- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.
- Premium subsidies will be provided to families with incomes between 100-400% of the poverty level (or $22,050 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium

to between 2% of income for those between 100-133% of the poverty level to 9.8% of income for those between 300- 400% of the poverty level.

- Cost-sharing subsidies will also be available to people with incomes between 100-200% of the poverty level to limit out-of-pocket spending.

Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage (existing individual and employer-sponsored plans do not have to meet the new benefit standards).

- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review before they can be implemented.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact under a single set of rules.
- Employers that impose a waiting period for health coverage of more than 60 days will be required to pay a penalty of $600 per full-time employee who is subject to the waiting period.

Employer Requirements

There is no employer mandate but employers with more than 50 employees will be assessed a fee of $750 per full-time employee if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $750 for each full-time employee.

- Employers that offer coverage will be required to provide a free choice voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income and who choose to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
- Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the bill will reduce the number of uninsured by 31 million in 2019 at a net cost of $871 billion over ten years. According to the CBO, by 2019, the bill will result in 26 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased insurance on their own in the individual market. In addition, 15 million more people will enroll in Medicaid and the Children's Health Insurance Program. The cost of the bill is financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The Congressional Budget Office estimates the proposal will reduce the deficit by $132 billion over ten years.

For more information about the Patient Protection and Affordable Care Act, see the side-by-side comparison of the health reform proposals at http://www.kff.org/healthreform/sidebyside.cfm.

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Affordable Health Care for America Act (H.R. 3962): Summary of Coverage Provisions

The Affordable Health Care for America Act was introduced in the House of Representatives on October 29, 2009 and was passed on November 7, 2009. The following summary explains key health coverage provisions in the legislation.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2013. Those who do not have coverage will be required to pay a financial penalty of 2.5% of adjusted gross income that is capped at the average cost of qualified coverage. Exceptions will be given to people with incomes below the tax filing threshold ($9,350 for individuals and $18,700 for couples), for religious objections, and for financial hardship.

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 150% of the federal poverty level ($16,245 for an individual and $33,075 for a family of four in 2009). This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a current limitation of the program that prohibits most adults without dependent children from enrolling in the program today. States will be required to maintain Medicaid eligibility levels above 150% of the poverty level into the future. The Children's Health Insurance Program (CHIP) will end in 2014; children with family incomes below 150% of the poverty level will move into Medicaid, while those with incomes above that level will obtain subsidized coverage through the newly created National Health Insurance Exchange.

- Medicaid coverage will be provided to all uninsured newborns until they can be enrolled in other coverage. In addition, states will be given the option to provide Medicaid coverage to low-income HIV-infected individuals and for family planning services to certain low-income women.
- The costs of the Medicaid expansion will be financed jointly between the federal government and the states. The federal government will provide 100% federal funding for the costs of those who become newly eligible for the program for two years (2013-2014). Beginning in 2015, federal financing for these costs will drop to 91%.

National Health Insurance Exchange

A National Health Insurance Exchange will be created where individuals and employers can purchase insurance. This new marketplace will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- People can only purchase coverage through the Exchange if they do not have other qualified health coverage, or if their share of the premium for coverage offered by an employer exceeds 12% of their family income. Access to plans in the Exchange will be phased-in for employers, starting with the smallest employers.
- Individuals will be able to choose among private plan options and a public plan. The public plan must meet the same requirements as private plans regarding the minimum benefits, provider networks, consumer protections, and cost-sharing.
- Plans in the Exchange will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required.

- Premium subsidies will be provided to families with incomes up to 400% of the poverty level ($88,200 for a family of four in 2009) to help them purchase insurance through the Exchange. These premium subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 3% of income for those at 150% of the poverty level to 12% of income for those at 400% of the poverty level. Cost-sharing subsidies will also be available to limit out-of-pocket spending.

Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status, gender, or occupation. These new rules will also require that all health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage (employer plans must comply with these coverage requirements by 2018).

- Health plan premiums will be allowed to vary based on age (by a 2 to 1 ratio), geographic area, and the number of family members.
- Health insurers will be required to spend at least 85% of their revenue on health coverage, rather than on administrative costs and profits, and they will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review before they can be implemented.
- Young adults will be allowed to remain on their parent's health insurance up to age 27.

Employer Requirements

Employers will be required to offer coverage to their employees and to contribute a specified share of the premium cost or pay a penalty of 8% of payroll. Small employers with total payroll of less than $500,000 will be exempt from the requirement and those with payroll between $500,000 and $750,000 that do not offer coverage will pay a reduced penalty.

- Small employers that employ lower-wage workers will be eligible to receive a tax credit to help them afford coverage for their employees.
- Employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the bill will reduce the number of uninsured by 36 million in 2019 at a net cost of $894 billion over ten years. According to the CBO, by 2019, the bill would result in 21 million people obtaining coverage in the newly created National Health Insurance Exchange, including some who previously purchased insurance on their own in the individual market. In addition, 15 million more people would enroll in Medicaid and an additional six million would obtain coverage through an employer. The cost of the bill is financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The Congressional Budget Office estimates the proposal will reduce the deficit by $109 billion over ten years.

For more information about the Affordable Health Care for America Act, see the side-by-side comparison of the health reform proposals at http://www.kff.org/healthreform/sidebyside.cfm

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