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The Consumer Connection

... linking consumers with health care news and information

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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

The Health Care Reform Bill:
What it means and does not mean

Probably the most discussed piece of legislation in our recent past as a nation, the Patient Protection and Affordable Care Act of 2010 will affect all Americans. Most of its provisions, however, are not yet well understood and require further clarification.

The law's implications are not well understood primarily because the law is more than 2,000 pages long, and public discussion has primarily focused on two specific areas: "death panels," which were NEVER part of the proposal, and the "public option," which is not in the final legislation as approved by the U.S. Congress and signed by President Obama on March 23, 2010.

What it does not mean

The law does not make big revolutionary changes in order to insure Americans without insurance coverage. It does not turn American doctors into government employees as they are in Great Britain. Nor does it create a government-run program as they have in Canada or as we have with Medicare for the elderly and persons with disabilities in the U.S.

What it does mean

In its April 22 release by Pat Regnier, assistant managing editor of CNNMoney.com, the author provides a straightforward description of what the new law attempts to do:

> {The law} weaves a loose safety net designed to catch people who don't get insurance at work and can't afford to buy their own, who lose their jobs, who have pre-existing conditions, or who want to create businesses and insure themselves and their workers. The Congressional Budget Office estimates that under the law eventually 94% of legal residents will have health coverage, up from 83% today.
>
> —"The truth about health care reform" CNNMoney.com, April 22, 2010

Following is a brief listing, by year, of changes that will occur under the provisions of the health care reform law. This listing is not exhaustive of the changes that will occur. Additional information can be obtained from the Kaiser Family Foundation, Focus on Health Reform, at www.kff.org, or from the Commonwealth Fund, http://www.commonwealthfund.org/Content/Publications/Other/2010/Timeline-for-Health-Care-Reform-Implementation.aspx.

Changes in 2010

- Coverage extended for young adults until age 26 on their parents' policies (effective September). See note on next page.
- State Medicaid and Children's Health Insurance Programs (MIChild in Michigan) must maintain their eligibility standards in place on March 23, 2010. States are permitted (effective April 1, 2010) to expand coverage to parents and childless adults with incomes up to 133 percent of the federal poverty level and receive standard (not enhanced) federal match. States must expand Medicaid coverage effective January 1, 2014.
- Subsidies (up to 35% of premiums) to help small businesses provide coverage to employees (tax years 2010–2013).

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- Employer plans and individual insurance policies barred from excluding children with pre-existing conditions or dropping coverage for persons who get sick (effective September).
- A $250 rebate for seniors whose drug costs put them into the "donut hole," the period when no assistance with drug costs is available under Medicare Part D. (Effective January 1, 2011, a 50% discount will be available for brand-name drugs for those who reach the donut hole).
- A reinsurance program available to employers to assist those providing coverage for early retirees, ages 55–64, (effective September).
- A temporary (until exchanges operational in 2014) high-risk pool to be established for individuals with pre-existing conditions who have been uninsured for six months.
- Prohibition of co-payments or deductibles for proven preventive services in qualified health plans (effective September).
- Lifetime limits on benefits are prohibited, and annual limits are restricted (effective September).
- Insurance companies are held accountable for unreasonable premium increases (Fiscal Year 2010).
- Website to be developed by July 1 to help individuals and businesses obtain information about insurance options.

Note: This provision in the law is scheduled to start on September 23, but several insurance companies have decided to implement the change early. As a result, young adults who are graduating from college this May and are on their parents' plans may be able to keep their coverage up to their 26th birthday. About 3.2 million students are graduating from college this May, and 67 percent of those are covered by their parents' plans.

Changes in 2011

- An insurance program supported by voluntary payroll deductions for people who project they may need assistance to remain in the community (rather than in a facility); five-year period of payments required for eligibility, the program will provide a cash benefit to help cover care costs.
- A 50 percent discount on brand name prescription drugs for seniors in the donut hole.

- No copayments or deductibles for recommended preventive services for Medicare beneficiaries.
- Fixed amount of revenue from insurance premiums (80%–85%) must be spent on medical care for enrollees, or a rebate to enrollees must be offered.
- Community health centers to receive an increase in funding.
- Investments to increase numbers of primary care practitioners (physicians and nurses).

Changes in 2014

Major provisions will be implemented, including the institution of "exchanges" (marketplaces) where people without employer coverage, as well as small businesses, can shop for a basic benefit package; no insurance company on the exchange will be allowed to deny coverage for pre-existing conditions, and women cannot be charged higher premiums than their male counterparts. Premiums based on age can only vary by a factor of three to one. The reform law's provisions taken together are expected to provide coverage for 32 million Americans currently uninsured.

The mandate that most Americans will have to carry coverage of a minimum package of benefits or pay a fine, $95, will be implemented ($695 a year or 2.5% of income whichever is higher by 2016). Persons and households who do not have the financial ability to purchase coverage will receive subsidies on a sliding scale; households with income under 400 percent of the federal poverty line can be assisted (roughly $88,000 for a family of four). Cost sharing subsidies will also be provided on a sliding income scale, and out-of-pocket expenses will be capped according to income level. The principle underlying the reforms is that all—young and old, healthy and sick—will participate in the risk pool.

Paying for the changes

A combination of approaches will be instituted to pay for the changes; these include: increased payroll (FICA) taxes on high income earners (over $200,000 annually) and a 3.8 percent tax on unearned income (combined changes projected to be an increase of $450 a year for a household earning $300,000); taxes on insurers as well as medical device and pharmaceutical manufacturers; changes and efficiencies in Medicare services and delivery, primarily reductions in payments for Medicare Advantage Plans (Part C) to bring them down to the level of fee-for-service payments; plans to "bundle" payments to providers for full care of their patients and move away from the fee-for-service system.

Winners and losers

The major winners are the nation's uninsured who will see their access to care increase in the coming years. Other winners include the insurance industry, scheduled to get 32 million new customers, and the physicians and hospitals who will provide their care. Uncompensated care costs should decline after 2014. Long term care providers will see increases in the ability of individuals to use their services. A big winner is the drug industry, with the significant subsidies provided to the elderly for their prescription use.

The major losers are cost control advocates, including major policy experts, who got little in the bill to address their serious concerns. And the single payer advocates who fell back to support a public option and lost on both counts. But most consider the bill a stepping stone and a good foundation to build a more rational system of care delivery and financing, an effort that can be improved upon as other social programs have been over the nation's history. It is as yet unknown whether those making the constitutional challenge on the mandate provision (including Michigan's attorney general) will be losers or winners, but constitutional law experts appear to think the case is not a winner.

Finally, from observations of Atul Gawande in *The New Yorker* dated April 5, 2010:
"That's the one truly scary thing about health reform: far from being a government takeover, it counts on local communities and clinicians for success. We are the ones to determine whether costs are controlled and health care improves—which is to say, whether reform survives and resistance is defeated. The voting is over, and the country has many other issues that clamor for attention. But, as L.B.J. would have recognized, the battle for health-care reform has only begun."

—Now What? By Atul Gawande, The New Yorker, April 5, 2010

We want to hear from you—suggestions for improvements and topics, questions, even encouragement!

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Notable numbers

- **$2.5 trillion:** total amount spent on U.S. health care in 2009. That's $8,047 per person and 17.3 percent of the entire economy.[1]
- **$1,666:** average cost of a single day in the hospital.[2]
- **17%:** percentage of employers that offered health benefits to Medicare-eligible retirees in 2009.[3] Percentage that offered such benefits in 1997: 28%. Percentage that offered such benefits in 1993: 40%.[4]
- **66%:** percentage of traditional plan participants who were extremely or very satisfied with their plan. Percentage of high-deductible health plan enrollees who were extremely or very satisfied: 40%.[5]
- **$13,700:** average cost of family coverage for a worker in a minimum wage position. That worker's average annual salary: $14,500.[6]
- **50%:** percentage of U.S. doctors who say they spend substantial time dealing with restrictions insurance companies place on their patients' care.[7]
- **46%:** percentage of U.S. doctors who use electronic medical records. Percentage of doctors in the Netherlands who do: 99%. [8]
- **1st:** rank of Vermont in terms of health care quality among U.S. states. 50th: Oklahoma's rank among the U.S. states.[9] (To view quality results for your state, use The Commonwealth Fund's interactive State Scorecard).
- **3rd:** rank of "preventable medical errors" on the list of leading causes of death in the U.S.[10] Number of deaths annually attributable to medical errors: nearly 200,000.
- **20%:** percentage of Americans who smoke.[11] Percentage who smoked in 1944: 41%.[12]
- **34%:** percentage of Americans who are obese today.[13] Percentage who were obese in the 1970s: about 16%.[14]

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[1] C. J. Truffer, S. Keehan, S. Smith et al., "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs Web First*, February 4, 2010: 467-77.

[2] S. Brownlee, Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer (New York: Bloomsbury USA, Sept. 2007).

[3] P. Fronstin, "2010 EBRI Trends in Retiree Health Benefits Offered by Employers" (Washington, D.C: Employee Benefits Research Institute, July 2010).

[4] P. Fronstin and V. Reno, "Recent Trends in Retiree Health Benefits and the Role of COBRA Coverage" (Washington, D.C.: National Academy of Social Insurance, June 2001).

[5] 2009 EBRI/MGA Consumer Engagement in Health Care Survey (Washington, D.C: Employee Benefits Research Institute. December 2009).

[6] S. Blakely, Employers, Workers, and the Future of Employment-Based Health Benefits (Washington, D.C: Employee Benefit Research Institute, Feb. 2010).

[7] C. Schoen, R. Osborn, M. M. Doty et al., "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171-w1183.

[8] Ibid.

[9] The Commonwealth Fund, State Data Center, http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009.aspx.

[10] HealthGrades Quality Study: Patient Safety in American Hospitals. July 2004.

[11] B. Hendrick, "Smoking Rate Is Declining in U.S.," *WebMD Health News*, Nov. 13, 2008, http://www.webmd.com/smoking-cessation/news/20081113/smoking-rate-is-declining-in-us.

[12] J. Jones, "Majority Disapproves of New Law Regulating Tobacco," June 26, 2009, http://www.gallup.com/poll/121079/majority-disapproves-new-law-regulating-tobacco.aspx.

[13] Centers for Disease Control and Prevention, FastStats: Obesity and Overweight, http://www.cdc.gov/nchs/fastats/overwt.htm.

[14] S. G. Leveille, C. C. Wee, and L. I. Iezzoni, "Trends in Obesity and Arthritis Among Baby Boomers and Their Predecessors, 1971-2002," *American Journal of Public Health*, Sept. 2005 95(9): 1607-13.

Notable Numbers is taken from the Commonwealth Fund's newsletter, *Purchasing High Performance*, dated May 3, 2010.