

**Consumers
Union**

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CONSUMER REPORTS



**Health Care
Reform:**

**How Will It
Affect You?**

Health Care Reform: How Will It Affect You?

The skyrocketing cost of health care places a heavy burden on every American. It is stifling economic growth, hurting our businesses both large and small and saddling the government with huge costs. Far too many Americans can't afford coverage and worry about how they will pay for medical care.

Congress and the nation is debating solutions to these problems – solutions that build on what works and fixes what doesn't, so that every American has guaranteed access to affordable, quality health care. As of this writing, nothing has been enacted into law but two comprehensive proposals are on the table. The proposals are complex because they are building on an already complex system.

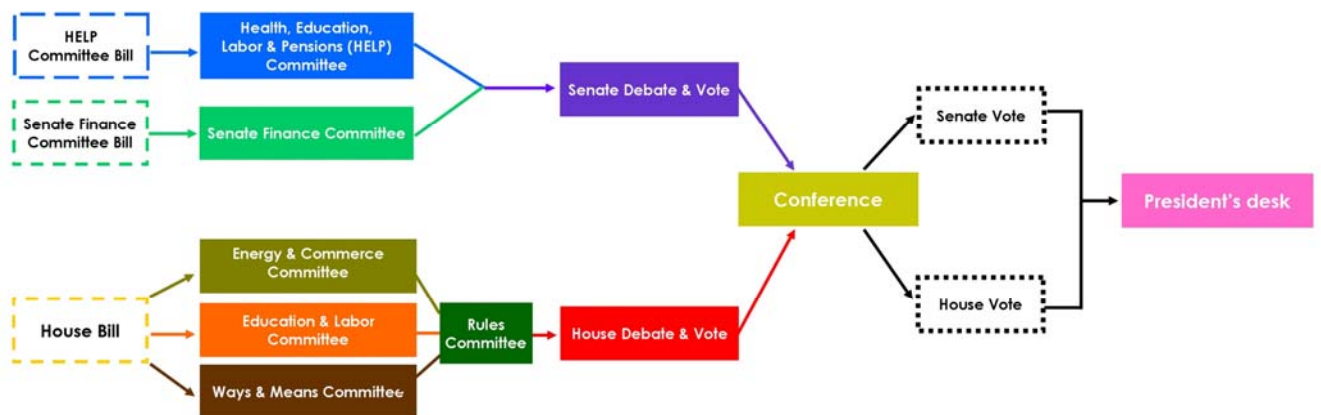
Below, Consumers Union presents some fictional families in different circumstances to illustrate how the proposals would affect the insurance choices you have now. You can also view these profiles online where they are linked to additional explanatory material ([www. prescriptionforchange.org](http://www.prescriptionforchange.org)).

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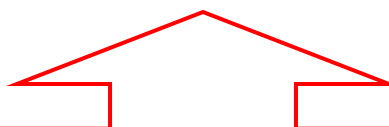
Passing Health Reform: The Legislative Steps

As the chart below shows, several House and Senate committees have jurisdiction over the various parts of our healthcare system. Since the summer, these various committees have been reconciling their differences with respect to the proposed health reform legislation. On November 7th, the House passed their version of the proposed reforms. On December 24th, the Senate passed their version—containing many similarities but also some key differences. Now the two chambers need to resolve the remaining differences in the proposals, both pass it, and finally send it to the President for signature.

As the proposals move forward and are modified, Consumers Union will update the descriptions of the impact on our 12 fictional families.



Source for chart: National Women's Law Center, 2009

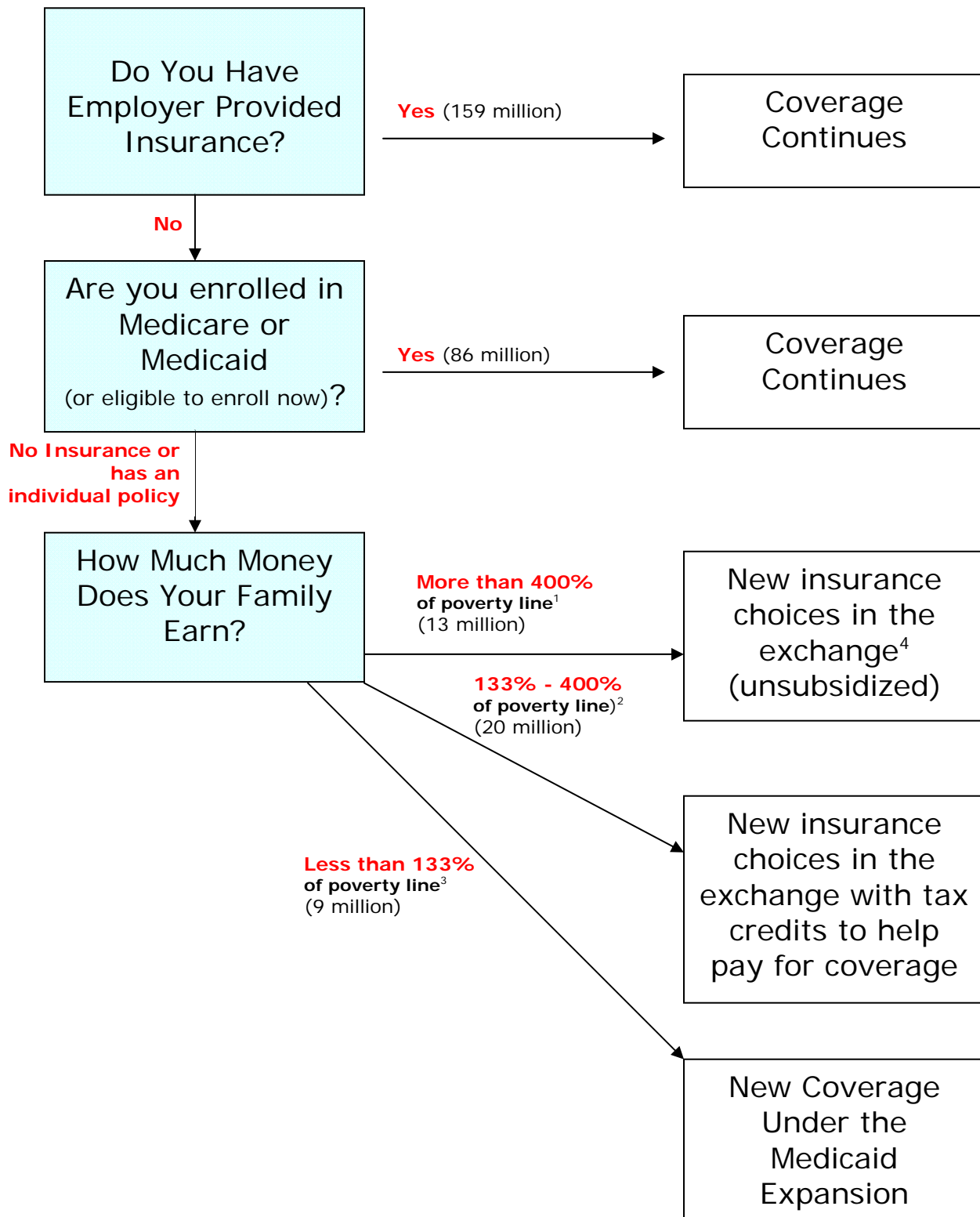


The process stands here

Senate: Passed their comprehensive health reform bill December 24, 2009.

House: Passed their comprehensive health reform bill November 7, 2009.

Overview of Coverage Options Under the Senate Health Reform Proposal



¹ In 2009, 400% of poverty line is \$43,300 per year for a single person; \$88,200/family of 4.

² In 2009, 133%-400% of poverty line is \$14,400-\$43,300 per year for a single person; \$29,300 - \$88,200/family of 4.

³ In 2009, 133% of poverty line is \$14,400 per year for a single person; \$29,300 /family of 4.

⁴ Small firms also have the option of purchasing coverage through the exchange, although their workers (regardless of income) aren't eligible for tax credits when the exchange coverage is offered through their employer.

How Health Reform would affect:

The Taylor family: good coverage through employer

Randy, 46, wife June, two children; Job: Computer analyst at large company. Income: \$90,000. Randy's family is covered through his job; he pays \$3,200 a year toward his share of the policy's premium.

Under proposed health reform bills

CHOICES

- The Taylors can keep the coverage they have now. Randy's employer is likely to continue offering health coverage to employees and contribute toward the family's premium.
- As they can today, the Taylors can opt out of their employer's coverage and purchase coverage "on their own" but this option is more expensive because the family would no longer have their employer's contribution to the premium.

COST

- The Taylors will continue to benefit from the financial security of having a comprehensive health insurance policy.
- After reform, large employer premiums are expected to stay much the same.

DIFFERENCES

House Bill (H.R. 3962, passed November 7, 2009):

- All but the smallest employers would be required to offer health coverage to employees and contribute a certain amount toward the family's premium, or pay a penalty. This minimum contribution is set at 72.5% of the premium for single coverage, and 65% for family coverage. Employers who don't offer coverage must pay up to 8 percent of their payroll into a fund that helps those purchasing coverage in the exchange.
- Eventually, all employer-based health coverage will have to meet certain standards, including preventive care, hospitalization, prescription drugs, etc. Most large companies' health plans already meet these standards.

Senate bill (H.R. 3590, passed December 24, 2009):

- As is the case today, employers are not required to offer coverage to workers. However, if they have more than 50 workers and one or more of those workers purchases health insurance using the new premium credits, then the employer will have to pay into a fund that helps finance those credits. In most cases, workers whose employer offers coverage are not eligible for these premium credits, thus the provision would apply to the tiny minority of employers who have more than 50 workers and don't offer coverage. If they have workers who enroll in Medicaid coverage, no employer fee is assessed.
- No coverage standards are imposed on large employers, although if their plan they offer falls below a certain standard, their employees may become eligible for tax credits in the exchange and the employer may be liable for the resulting fee.
- A 40 percent excise tax would be levied against employers that offer so-called "Cadillac" plans, which total more than \$8,500 for individuals and \$23,000 for families. That threshold would grow along with inflation. Employers whose workers engage in high-risk professions would be exempt from the tax.

How Health Reform would affect:

Frank: high-deductible insurance through his job

Frank, 57, has insurance but struggles to get care for his high cholesterol. Every year he must pay out-of-pocket until he meets his \$1,500 deductible, and he has difficulty finding doctors who will take his coverage. Income: \$35,000.

Under proposed health reform bills:

CHOICES

- Frank could keep his coverage through his job. Frank's employer is likely to continue offering health coverage to employees and contribute toward his premium.
- Or, Frank could get coverage on his own through a new health insurance "store" or exchange with a variety of choices—an important safety-net should Frank lose his employer coverage.
- Reforms include provisions to increase the number of primary care providers, which could make it easier for Frank to find a doctor.

COSTS

- If Frank continues insurance from his job, his costs may stay about the same.
- As long as his job offers him qualified coverage, Frank won't qualify for premium credits to buy coverage in the exchange – making exchange coverage more expensive than the coverage through his employer. (Frank's employer pays a large portion of the premium, so Frank's share is far less than the total cost of the coverage.)

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- All but the smallest employers would be required to offer health coverage to employees and contribute a certain amount toward the premium, or pay a penalty. This minimum contribution is set at 72.5% for single coverage and 65% for family coverage.
- Eventually employers must offer coverage that meets minimum standards. However, high-deductible plans such as Frank's would likely meet that standard.

Senate bill (H.R. 3590, passed December 24, 2009):

- As is the case today, employers are not required to offer coverage to workers. However, if they have workers who purchase health insurance using the new premium credits, then the employer will have to pay into a fund that helps finance those credits. If they have workers who enroll in Medicaid coverage, no employer fee is assessed.
- No coverage standards are imposed on large employers, although if their plan they offer falls below a certain standard, their employees may become eligible for tax credits in the exchange and the employer may be liable for the resulting penalty.

How Health Reform would affect:

Penelope: small-business owner struggling to cover her employees

Penelope, 48, graphic design shop owner, has 8 employees with annual payroll of \$400,000. She provides coverage for workers but premiums have increased 10% each year and she now offers only high-deductible coverage (\$5,000). Penelope is a breast-cancer survivor.

Under proposed health reform bills:

CHOICES

- The coverage that Penelope offers now can be continued because it is “grandfathered.”
- Alternatively, Penelope could purchase coverage for herself and her workers through a new type of store called the health exchange, where employees will have a choice of plans. Penelope can contribute a fixed amount to her employees’ coverage and then let them pick the plan that suits them best. Her employees would then pay the balance of their premiums.
- Small businesses would also have the option of purchasing coverage outside the exchange. Insurers who do this would have to follow the same rules as insurers in the exchange.

COSTS

- New rules determine how premiums are set. Among other things, insurers cannot charge more due to pre-existing medical conditions or refuse to cover such conditions.
- As more people come into the insurance “pool” and competition increases among plans in the exchange, Penelope and her employees may see their premium increases moderate over time.
- Many small businesses will be eligible for new tax credits to help pay the cost of coverage, but Penelope’s firm pays an average salary of \$50,000 and may not qualify.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Businesses with a total annual payroll higher than \$500,000 would either have to offer coverage to workers, or pay into a fund. Penelope’s payroll is less, so she would be exempt from this requirement.
- Small firms must have fewer than 25 employees and an average salary of under \$40,000 to qualify for the new small business tax credits. Because Penelope’s business has an average salary of \$50,000, her firm would not qualify.
- Although Penelope is not obligated to offer coverage, if she does, the coverage would eventually have to meet new, minimum standards for coverage, including a requirement for lower deductibles.
- The new national exchange would feature a new public insurance plan option, in addition to private options.

Senate bill (H.R. 3590, passed December 24, 2009):

- Employers with fewer than 50 employees (like Penelope) do not have to pay a fee if their employees avail themselves of the new tax credits for lower income families purchasing “on their own” in the exchange.
- Small firms must have fewer than 25 employees and an average salary of under \$50,000 to qualify for small business tax credits. Penelope might qualify, but her credit would be small as she is near the wage level cut-off for the credit.
- The new state-based exchanges would feature new “multi-state” plan options – new, national private insurance plans regulated by a federal agency, at least one of which would be a non-profit plan.

How Health Reform would affect:

Bernie & Elise: can't start a business due to health coverage

Bernie, 35, would love to quit his construction job (income: \$65,000) and start a home building business. But wife, Elise, has diabetes. Bernie fears they won't get affordable health coverage on their own, so they've put off their dream to keep his employer-offered coverage.

Under proposed health reform bills:

CHOICES

- Bernie and Elise could reconsider their dream due to new health coverage options. They can shop for insurance in a new "store" called the health insurance exchange, where they would have a choice of plans.
- They couldn't be denied coverage due to a pre-existing condition like diabetes. Insurers couldn't charge higher premiums for such conditions.
- Policies offered in the exchange will cover diabetes tests, supplies and other treatments that Elise needs, with no unexpected gaps in covered benefits.

COSTS

- If Bernie and Elise start their own business, they may qualify for help paying for coverage (as individuals) through the exchange, depending on how much income they make.
- If they employ others, they might qualify for new tax credits for small businesses who cover their employees (see below), but they wouldn't be allowed to "double dip" and get both the individual and business credits.
- The couple may see annual premium increases moderate over time as insurance plans compete for customers in the exchange.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- The new national exchange would feature a new public insurance plan option, in addition to private options.
- Small firms must have fewer than 25 employees and an average salary of under \$40,000 to qualify for small business tax credits.

Senate bill (H.R. 3590, passed December 24, 2009):

- The new state-based exchanges would feature new "multi-state" plan options – new, national private insurance plans regulated by a federal agency, at least one of which would be a non-profit plan.
- Small firms must have fewer than 25 employees and an average salary of under \$50,000 to qualify for small business tax credits.

How Health Reform would affect:

Enrique: self-employed, pays a lot for coverage

Enrique, 51, single, consultant. Income: \$60,000. Like many people with individual policies, he has a high deductible (\$4,000) and premiums that increase regularly. Having been treated in past for depression, he can't find more affordable coverage.

Under proposed health reform bills:

CHOICES

- Enrique will have a variety of choices in a new "store" called the health insurance exchange.
- Whichever plan he picks must cover his mental health needs as part of the new minimum benefits package. Insurers could not exclude Enrique for his pre-existing condition or charge higher premiums because of the condition.
- Depending on the proposal, Enrique could also buy coverage outside the exchange.
- Enrique could also keep his current coverage. It is "grandfathered" and doesn't have to meet the new minimum benefit requirements.

COSTS

- Enrique's new insurance choices would feature lower deductibles. New rules would limit how much of overall medical expenses the patient is expected to pay.
- Enrique may see his annual premium increases moderate over time as health plans compete for customers. New rules require everyone get coverage and determine how premiums are set. This should even out premium increases, as more people come into the insurance "pool."
- At his income, Enrique would not qualify for the new premium credits that would help lower-income individuals afford coverage.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Individuals could not buy coverage outside the exchange, except for "grandfathered" coverage that was already in place (like Enrique's coverage).
- The new national insurance exchange would feature a new public insurance plan option, in addition to private options.

Senate bill (H.R. 3590, passed December 24, 2009):

- Enrique could still buy an individual policy outside the health insurance exchange. This coverage would have to follow most of the same "rules" as coverage in the exchange, although insurers would not have to use the same standardized forms to describe their products as used in the exchange.
- The new state-based exchanges would feature new "multi-state" plan options – new, national private insurance plans regulated by a federal agency, at least one of which would be a non-profit plan.

How Health Reform would affect:

The Greens: no employer coverage, family on Medicaid

Leonard, 31, works for small contractor that doesn't offer insurance to employees. Wife Angela, 29, stays at home with their two kids. Income: \$32,000. They live in one of the 12 states (plus DC) that offers Medicaid to both children and parents at this income level.

Under proposed health reform bills:

CHOICES

- The Green's Medicaid health coverage would continue. At least until 2013 (depends on the proposal), states would be required to maintain programs like this that are already in place.
- Or, Len's employer could begin to offer coverage because the firm may qualify for new tax credits that help small businesses pay the cost of coverage.
- Depending on the proposal, Len may be able to get affordable coverage through the new health insurance exchange, featuring a variety of health insurance choices.

COSTS

- The Green's cost for Medicaid coverage will likely continue to have low premiums or non-existent premiums.
- Depending on the proposal, Len may be able to get premium credits to pay for coverage through the new health insurance exchange.
- If Len's employer decides to offer coverage, Len's cost could be as high as 35% to 40% of the premium, depending on how much his employer decides to contribute. Len isn't required to enroll – he can keep his Medicaid coverage if that's better for his family.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Medicaid eligibility rises to 150% of Federal Poverty Level (FPL) for all legal residents, including childless adults. States that currently maintain higher thresholds must continue to do so.
- Medicaid-eligible individuals do not qualify for premium credits to purchase in the exchange.

Senate bill (H.R. 3590, passed December 24, 2009):

- Medicaid eligibility rises to 133% of FPL for all legal residents, including childless adults. States that currently maintain a higher threshold for children must continue to do so until 2019. States that currently maintain higher eligibility thresholds for adults must continue to do so until the exchanges are operational in 2014. Exception: states with budget deficits can roll back coverage levels if above 133% FPL.
- After the exchanges open in 2014, Medicaid-eligible adults with incomes higher than 133% of FPL (like the Greens) may be able to purchase in the exchange, depending on whether their state rolls back the eligibility threshold for this coverage to the new national standard.

How Health Reform would affect:

Beth: Uninsured, but children are covered

Beth, 34, two children. Sales associate at large discount store. Income: \$34,000. Beth can't afford her share of health insurance premium (50% of the total premium) offered through her job, so she's uninsured. Kids get coverage through her state's children's health insurance program (CHIP). She pays \$10 a month per child and low co-pays.

Under proposed health reform bills:

CHOICES

- Beth's employer may decide to pay a larger portion of the cost of her health insurance premium, making this a more affordable option for Beth.
- Beth could also buy coverage for her family through a new health insurance "store" or exchange with a variety of choices.
- Depending on the bill, CHIP coverage for Beth's kids would either continue or be replaced by the new options in the exchange.
- Beth would have to get coverage unless she can show she can't afford it.

COST

- If the cost of employer coverage remains very high, Beth could qualify for premium credits to purchase a policy in the exchange. What constitutes "very high" depends on the bill.
- Beth's employer might begin to pay more towards coverage in order to avoid penalties (see below). However, an employer can avoid penalties and still leave Beth with costs that are quite high--as much as 27.5% to 40% of the cost--depending on the proposal and whether she includes her kids on the policy.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Her employer would pay at least 72.5% of Beth's individual premium, or 65% of the cost for a family premium. If her employer doesn't, they must pay into a fund to help cover lower-income people.
- Beth can only get help paying for coverage in the exchange if her share of the cost of employer coverage exceeds 12% of her income. Otherwise, people with employer coverage are not eligible for premium credits in the exchange.
- The CHIP program for low-income children would end once affordable coverage is available in the exchange. CHIP enrollees with incomes below 150% of poverty would be moved to Medicaid.

Senate bill (H.R. 3590, passed December 24, 2009):

- Employers are not required to offer coverage. However, if they have workers who purchase health insurance using the new premium credits, the employer will have to pay into a fund that helps finance those credits.
- To get help paying for her coverage in the exchange, Beth's cost for her share of her employer coverage must exceed 8% of her income. At this level, Beth can use the premium contribution her employer normally makes to purchase coverage in the exchange. If her cost for employer coverage is even higher, exceeding 9.8% of her income, she will qualify for individual tax credits in the exchange. Otherwise, people with employer coverage are not eligible for premium credits in the exchange.
- CHIP coverage is still available to low-income children, like Beth's.

How Health Reform would affect:

Vince: young, uninsured, works part-time

Vince, 25, waiter and student. Income: \$10,000 – too high to be eligible for Medicaid. Too old to be on his parent's policy.

Under proposed health reform bills:

CHOICES

- Vince could get coverage in a broadened Medicaid program, which will be expanded to include more low-income workers. Currently, Medicaid is reserved mainly for families with children living at or near the poverty level, and is rarely extended to single adults.
- Or, Vince's employer might start covering part-time workers. If his job doesn't offer health insurance, the employer may have to contribute to a fund that helps pay for coverage for low-income people like Vince.
- Vince would have the immediate option of remaining on his parent's health coverage, if his parents have access to private individual or employer coverage.
- Vince must have coverage unless he can show he can't afford it.

COST

- Vince would likely have no, or very small co-pays for medical services, under Medicaid. Premiums will be low or non-existent.
- Medicaid-eligible persons cannot get premium credits to purchase coverage in the exchange.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- To qualify for Medicaid, individuals can make no more than \$16,250 per year. Larger families could have higher income levels and still qualify.
- Allows young adults to stay on their parents' coverage through age 26.

Senate bill (H.R. 3590, passed December 24, 2009):

- To qualify for Medicaid, individuals can make no more than \$14,500 per year. Larger families could have higher income levels and still qualify.
- Allows young adults to stay on their parents' coverage through age 25.

How Health Reform would affect:

Mia: laid-off, can't afford COBRA coverage

Mia, 56, is unemployed and uninsured. She couldn't afford the COBRA premium after her layoff. Income: \$20,000 from temp work. Her high blood pressure is a pre-existing condition, making it difficult to find an affordable policy.

Under proposed health reform bills:

CHOICES

- Mia will be guaranteed access to an affordable policy through a new "store" called the health insurance exchange, which would offer a variety of plans.
- Depending on the proposal, she could also buy coverage outside the exchange but without help to pay for it.
- Insurers may not deny coverage to people with pre-existing conditions or charge them a different amount, even for policies sold outside the exchange.
- Mia would have to get coverage unless she can show she can't afford it.

COSTS

- Because she makes far less than 400 percent of the Federal Poverty Level, Mia would get premium credits to help pay for coverage purchased through the exchange. At her income, she would be expected to pay between 3 and 4.6% of her income for the premium (up to \$900 a year).
- Mia's share of costs for medical services (co-pays and deductibles) would vary, depending on the proposal.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Individuals couldn't buy coverage outside the insurance exchange.
- The new national exchange would feature a new public insurance plan option, in addition to private options.

Senate bill (H.R. 3590, passed December 24, 2009):

- Mia would have the option of buying a policy outside of the exchange, but if she did, she could not get help paying for this coverage.
- The new state-based exchanges would feature new "multi-state" plan options – new, national private insurance plans regulated by a federal agency, at least one of which would be a non-profit plan.

How Health Reform would affect:

Brian: Disabled and Uninsured

Brian, 39 and divorced, was in an accident six months ago that left him permanently disabled. Unable to work, he lost his employer health coverage. Income: \$16,000 a year from disability insurance policy. He's applying for Medicare, which is available to disabled people even if they are under age 65, but it takes two years before coverage kicks in. Brian makes too much to get Medicaid coverage now.

Under proposed health reform bills:

CHOICES

- Brian will receive substantial help, but his choices differ depending on the proposal.
- Under one bill, Brian could enroll in a broadened Medicaid program. This coverage would be more comprehensive than the Medicare coverage he is waiting for.
- Under the other bill (where he is ineligible for Medicaid), Brian could buy coverage in the new health insurance exchange. This coverage may be more comprehensive than the coverage he is waiting to get in Medicare. Once eligible for Medicare, however, Brian will no longer be eligible for coverage in the exchange. Brian also has the option of buying health insurance outside the exchange but he won't get any premium credits to purchase this coverage.
- Insurers may not deny coverage to people with pre-existing conditions or charge them a different amount, even for policies sold outside the exchange.
- Brian must have coverage unless he can show he can't afford it.

COSTS

- With Medicaid coverage, Brian would have no or only small co-pays for drugs and doctor visits. He'd likely pay little to no premium. Medicaid would be cheaper than the coverage he's waiting for under Medicare.
- Under the other proposal, Brian would get substantial help paying for his coverage in the exchange. He would be expected to pay less than 4% of his income for his premium (less than \$300 a year). His costs for medical services would also be affordable.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Brian would now qualify for Medicaid because he makes less than \$16,250 per year. (Larger families can make more and still qualify.) Because he is eligible for Medicaid, Brian doesn't qualify for premium credits to buy coverage in the exchange.
- Individuals couldn't buy coverage outside the insurance exchange.

Senate bill (H.R. 3590, passed December 24, 2009):

- Brian wouldn't qualify for Medicaid because *individuals* can make no more than \$14,500 per year.
- At his income, Brian would qualify for premium credits to help purchase coverage in the exchange.
- Brian would have the option of buying a policy outside of the exchange. He could not get premium credits to help pay for this coverage.

How Health Reform would affect:

Harriet & Luis: Retirees with Medicare Coverage

Harriet, 70, and Luis, 67, have traditional Medicare health coverage and "Part D" prescription drug coverage. They also buy a supplemental "Medi-gap" policy to cover costs Medicare doesn't. They worry about Medicare's security and whether there will be cuts in their Medicare coverage. Income: \$50,000.

Under proposed health reform bills:

CHOICES

- The couple will still have their Medicare health care and prescription drug coverage, and the choice of buying a supplemental "Medi-Gap" policy.
- All their benefits are preserved. Preventive care and prescription drug benefits would improve.

COSTS

- The couple won't have to pay anything for preventive services like physicals, mammograms, glaucoma screening and other services as they do now.
- The cost of many medicines in the "Part D" doughnut hole will be lower.
- They could have better choices of primary care doctors because those types of health care providers will get paid more.
- Money-saving measures and efforts to reduce fraud, waste and overpayments strengthen the long-term financial health of Medicare so it doesn't "run out of money."

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- The current coverage gap in their Part D prescription drug coverage (the "doughnut hole") will be filled in over time, so more of their prescription costs will be covered. The doughnut hole is eliminated by 2018.

Senate bill (H.R. 3590, passed December 24, 2009):

- The current coverage gap in their Part D prescription drug coverage (the "doughnut hole") will be reduced by \$500, but the gap does not close completely.

How Health Reform would affect:

Kim & Oscar: Retirees with Medicare Advantage Coverage

Kim, 70, and Oscar, 74, don't have traditional Medicare, but a privately run "Medicare Advantage" plan that covers the same services as Medicare, plus extra benefits (like eyeglasses). They know this program by the name on their insurance card, and may not be familiar with the term Medicare Advantage.

Under proposed health reform bills:

CHOICES

- Kim and Oscar will still have the option of enrolling in a Medicare Advantage plan.
- As they do now, Kim and Oscar also have the option of enrolling in "traditional" Medicare.
- Some Medicare Advantage plans may alter their benefits due to changes in the way they are paid by the Federal government.

COSTS

- Medicare will stop paying private insurance companies extra to enroll seniors in Medicare Advantage plans. Today, these plans are paid roughly 14% more than what the same senior would cost in traditional Medicare and this has accelerated the depletion of the Medicare trust funds. Aligning the costs of Medicare Advantage plans with traditional Medicare will save taxpayers money and help ensure that both types of coverage can be sustained in the future.
- Medicare Advantage plans are prohibited from charging cost-sharing that is higher than that charged under traditional Medicare.
- Under either program, the couple won't have to pay for preventive services like physicals, mammograms, glaucoma screening and other services.

DIFFERENCES

House bill (H.R. 3962, passed November 7, 2009):

- Under this proposal, "equivalency" between traditional Medicare and Medicare Advantage is phased in starting in 2011 and ending in 2013.

Senate bill (H.R. 3590, passed December 24, 2009):

- Under this proposal, "equivalency" between traditional Medicare and Medicare Advantage is phased in starting in 2012 and ending in 2015, with special transition assistance for regions that currently have very high levels of Medicare Advantage benefits.

Summary of the New Proposals

House bill (H.R. 3962, passed November 7)	Senate bill (H.R. 3590, passed December 24):
Individual Mandate	
<p>Everyone must enroll in health coverage or face a penalty equal to 2.5% of their income (but the penalty can't exceed the cost of the coverage itself). A person is exempt from the penalty if they can demonstrate there's no insurance option they can afford.</p>	<p>The same except that the penalty starts at \$95 per uncovered family member in 2014 (or .5% of income, which ever is greater), rising to \$750 per year by 2016 (or 2% of income, which ever is greater).</p>
New Health Insurance Store	
<p>For those without a "qualified" coverage option (such as employer coverage, Medicaid, Medicare, or military health coverage), there are new coverage options offered through a type of store called the health insurance exchange.</p> <p>The national exchange would feature a new public insurance plan option, in addition to private options.</p>	<p>Similar, except the exchange would operate at the state, rather than the national level.</p> <p>The state exchanges would feature new "multi-state" plan options – new, national private insurance plans regulated by a federal agency, at least one of which would be a non-profit plan.</p>
Medicaid	
<p>Medicaid is expanded to include all low-income people (citizens and legal immigrants) who make less than 150% of the "federal poverty level." That means individuals with annual incomes up to about \$16,250, and couples with incomes about \$21,900 could now qualify. Larger families could have higher income and still qualify for Medicaid.</p> <p>States with more generous Medicaid eligibility standards are required to maintain them.</p> <p>Increases payment rates for primary care providers.</p>	<p>Medicaid is expanded to include all low-income people (citizens and legal immigrants) who make less than 133% of the federal poverty level.</p> <p>If higher, states are required to maintain Medicaid eligibility standards currently in place for adults until 2014 and eligibility standards for children until 2019.</p>
CHIP	
<p>The State Children's Health Insurance Program would be eliminated in 2014. CHIP eligible children would move to Medicaid (if under 150% of FPL) or would purchase discounted coverage through the exchange.</p>	<p>CHIP-eligible children will have the choice of enrolling in their state's CHIP program or using credits to purchase coverage through the exchange. Federal financing for CHIP is extended through 2015.</p>
New Rules for Insurance Companies	
<p>Insurers can no longer deny coverage based on someone's pre-existing medical condition.</p> <p>The premiums they charge can only vary by age, geographic area and family size within a given benefit design. Variation for age cannot exceed 2:1 meaning that the oldest policyholders cannot pay more than twice that of youngest policyholders.</p> <p>Until 2013, insurers must also spend a set portion of those premiums for medical care, as opposed to profits or administration. If the spending on medical care falls below that amount, the excess premium must be rebated to policyholders.</p> <p>Must allow children through age 26 to stay on their parents' individual or group health plans.</p>	<p>Similar: Insurers can no longer deny coverage based on someone's pre-existing medical condition.</p> <p>Within a given benefit design, the premiums they charge can only vary by age, tobacco use, geographic area and family size. Variation for age cannot exceed 3:1.</p> <p>Until 2014, insurers must also spend a set portion of those premiums for medical care, as opposed to profits or administration. If the spending on medical care falls below that amount, the excess premium must be rebated to policyholders</p> <p>Must allow children through age 25 to stay on their parents' individual or group health plans.</p>
Help Paying for Coverage	
<p>Individuals and families under "400% of the federal poverty level" can get help paying for their premiums if their coverage is purchased in the exchange. Premium credits would be available on a progressive sliding scale for single person who makes less than \$43,000 a year. Larger families are eligible at higher income levels.</p> <p>If they have other qualified coverage (like employer coverage), they are not eligible for this help, unless their cost of that employer coverage exceeds 12% of income.</p>	<p>Similar: Individuals and families under "400% of the federal poverty level" can get help paying their premiums if their coverage is purchased in the insurance exchange. The amount of income the family is expected to contribute (after subsidy) is generally higher than in the House bill. Also, the coverage that the subsidy purchases is somewhat less generous than the House bill.</p> <p>If they have other qualified coverage (like employer coverage), they are not eligible for this help, unless their cost of that employer coverage exceeds 9.8% of income.</p>

Summary of the New Proposals (continued)

House bill (H.R. 3962, passed November 7)	Senate bill (H.R. 3590, passed December 24):
Employer Incentives to Cover Workers	
<p>All employers with a total payroll greater than \$500,000 face new requirements, but they are similar to what most employers do now. Employers can either contribute to coverage for their workers, or they can pay into a fund that helps pay for coverage for workers purchasing in the health exchange.</p> <p>If an employer chooses to contribute to employees' coverage, they must contribute a certain level (for example, 72.5% of the premium for single coverage for a full-time worker). After five years, this contribution must be for coverage that meets certain standards (for example, covered benefits must include preventive care, hospitalization, prescriptions, etc). Most companies' current health plans would meet the standards. Smaller employers (total payroll less than \$500,000) are exempt from this requirement.</p>	<p>If an employer has over 50 workers and has workers who purchase health insurance using the new tax credits, then the employer will have to pay into a fund that helps finance those credits.</p> <p>Generally, workers with an employer coverage option cannot get coverage to purchase in the exchange. Thus, the provision would mainly apply to employers with more than 50 employees who don't offer coverage.</p> <p>If they have workers who enroll in Medicaid coverage, no employer fee is assessed.</p>
COBRA	
<p>COBRA coverage would continue.</p> <p>The bill extends the period of COBRA eligibility by allowing laid-off workers to continue COBRA until they become eligible under a new employer's health plan or for coverage in the health exchanges.</p>	<p>The Senate bill continues current law with respect to COBRA.</p>
Special Rules for Small Employers	
<p>In 2013 (the first year of operation), small employers with 25 or fewer employees may offer the exchange coverage to their employees. These employers would have to comply with the new rules regarding minimum employer contributions to workers' coverage (for example, 72.5% of the premium for single coverage for a full-time worker). Employers up to size 100 may offer exchange coverage in later years. (Employees who purchase in the exchange through their employers are not eligible for the premium discounts offered to lower-income individuals who buy in the exchange.)</p> <p>Very small employers with low-wage employees could receive a tax credit to defray some of the cost of coverage. These employers must have an average wage of less than \$40,000 and fewer than 25 employees. The maximum tax credit is 50% of the employer's contribution to the premium. The size of the credit declines as employer size goes above 10 employees and average wage goes above \$20,000.</p> <p>Employers with a total payroll of less than \$500,000 are exempt from the new rules requiring employers to either meet minimum standards for coverage for workers, or to contribute to a fund that helps pay for coverage for lower-income individuals.</p>	<p>In 2014, employers with 50 employees or less may offer the exchange coverage to their employees. As in the House bill, employees who purchase in the exchange through their employers are not eligible for the new premium credits that individuals who buy in the exchange can apply for.</p> <p>Beginning in 2014, small businesses up to 100 employees can purchase coverage through the exchange.</p> <p>Small businesses are eligible for tax credits similar to those in the House proposal, except that the credits are only available for exchange coverage and employers with an average wage of \$50,000 are eligible.</p> <p>Employers with 50 workers or less are exempt from the new penalties facing larger employers if their workers purchase health insurance using the new individual tax credits.</p>

Summary of the New Proposals (continued)

House bill (H.R. 3962, passed November 7)	Senate bill (H.R. 3590, passed December 24):
Medicare	
<p>Beginning in 2011, the Part D coverage gap known as the "doughnut hole" will begin being phased out, so by 2019 the gap disappears. During this phase out, seniors who fall into the doughnut hole would get discounts of 50% for brand-name drugs.</p> <p>If a drug plan makes a change to its list of covered drugs that increases the senior's costs or reduces their coverage, that person has the right to change plans before the end of the plan year.</p> <p>Preventive services such as physicals breast exams, mammograms, glaucoma screening and other services would be completely paid for (no co-pays). Payment rates for primary care providers would also increase.</p> <p>Provides new funding for research into treatments for chronic diseases that affect many elderly Americans.</p> <p>Attempts to cut waste and end overpayments to insurance companies to strengthen the long-term financial health of Medicare and provides incentives to improve care for seniors treated in the hospital so they are not rehospitalized.</p>	<p>Provisions are similar to those in the House bill EXCEPT the "doughnut hole" is NOT phased out. The "doughnut hole" is narrowed by \$500 and seniors who fall into the doughnut hole would get discounts of 50% for brand-name drugs.</p>
Medicare Advantage Plans	
<p>Because the government currently pays private Medicare Advantage plans about 14% more for each senior enrolled than in traditional Medicare, a new payment method will seek to lower those taxpayer costs and help extend the life of the Medicare Trust Fund. By 2013 payments to Medicare Advantage plans must equal the average cost of "traditional" Medicare enrollees in that geographic area.</p> <p>Prohibits Medicare Advantage plans from charging cost-sharing for specific services (like home health) that exceeds the cost-sharing in traditional Medicare.</p> <p>Beginning 2014, requires Medicare Advantage plans to spend at least 85% of their premium revenues (from enrollees and from the government) on medical services. If plans spend less, they must rebate the difference to their enrollees.</p>	<p>Provisions are similar to those in the House bill EXCEPT :</p> <ul style="list-style-type: none"> • Parity between Medicare advantage payments and traditional Medicare is phased in between 2012 and 2015 with special transition assistance provided for regions with very high levels of Medicare Advantage benefits currently. • Does not collect or publish health plan medical loss ratios.

Health Reform: Proposed Implementation Timeline

Year	House Bill (November 7):	Senate bill (December 24)
2010	<ul style="list-style-type: none"> • Young adults, age 26 and younger, can stay on their parents' policy. • Persons denied coverage due to pre-existing conditions may enroll in new temporary high risk pool. • Improves preventive health coverage in Medicare. 	<ul style="list-style-type: none"> • Young adults, age 25 and younger, can stay on their parents' policy. • Persons denied coverage due to pre-existing conditions AND who have been uninsured for six months may enroll in new temporary high risk pool. • Phase I of Small Employer Tax credit begins (can be used with any coverage). • Reduces the Medicare Part D Prescription Drug coverage gap known as the "doughnut hole" by \$500. • Insurers must cover children, regardless of their pre-existing conditions.
2011	<ul style="list-style-type: none"> • Begins to fill in the Medicare Part D Prescription Drug coverage gap known as the "doughnut hole." 	<ul style="list-style-type: none"> • States have the option of using Medicaid to cover childless adults.
2013/2014	<p>In 2013:</p> <ul style="list-style-type: none"> • Health Insurance Exchange begins. Individuals and firms under 25 employees can enroll. • Prohibits insurance companies from discriminatory practices (like denying pre-existing conditions). Limits the insurance companies' ability to charge higher rates due to health status, gender or other factors. • Public Health Insurance option is created. • All legal residents, with incomes 150% of poverty and below, are eligible for Medicaid coverage. • Premium credits begin - available to people with incomes above Medicaid eligibility and below 400% of poverty. • Requirement that individuals have health insurance begins. • Employer penalties begin - larger employers are required to offer coverage to their workers and families or pay a penalty. • Small Employer Tax Credit begins. <p>In 2014:</p> <ul style="list-style-type: none"> • Exchange expands to small businesses with up to 50 employees. • CHIP coverage ends. Enrollees move to Medicaid or the exchange. 	<p>In 2013:</p> <ul style="list-style-type: none"> • High cost health insurance ("Cadillac") tax begins. <p>In 2014:</p> <ul style="list-style-type: none"> • Health Insurance Exchange begins. Individuals and Firms under size 100 can enroll. • All plans offered in the individual markets, whether in or out of the exchange, must comply with insurance rating reforms. • All legal residents, with incomes 133% of poverty and below, are eligible for Medicaid coverage • Individual tax credits begin, for people with incomes above Medicaid eligibility and below 400% of poverty. • Requirement that individuals have health insurance begins. • Begin 5-year phase in of small group market insurance reforms. • Employer penalties begin - employers with over 50 employees and with workers who receive tax credits in the exchange face a penalty. • Phase II of Small Employer Tax credit. Credit can only be used for coverage through the exchange.
2015	<p>Health Insurance Exchange expands to small businesses up to 100 employees, with an option to include larger businesses.</p>	<ul style="list-style-type: none"> • Interstate "health insurance compacts" may form. • State "opt out" arrangements may begin.
2017/2018	<p>In 2018:</p> <ul style="list-style-type: none"> • Employers required to meet essential benefits package standards. • Medicare "doughnut hole" eliminated. 	<p>In 2017:</p> <p>At state's option, businesses with over 100 employees can purchase in Health Insurance Exchange.</p>

Glossary of Health Reform Terms

Affordability Credits: These credits would help lower the cost of coverage purchased through the exchange. Information about a family's income and size is used to determine whether the family qualifies for the credits and if so, what type of contribution the family is expected to make.

Benefit Design, Benefit Package: The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit design or package also refers to how costs for these covered services are shared between the patient and the insurance company. For example, the benefit design might require the patient to pay a \$25 copay when they visit the doctor, but the insurance plan pays the rest of the cost of the visit.

Brand Name Drug: A drug that has a trade name and is protected by a patent (can be produced and sold only by the company holding the patent). In contrast, generic drugs have come "off" patent and can be manufactured and sold by any company. Brand drugs are typically much more expensive than their equivalent generic counterparts.

CHIP: The Children's Health Insurance Program (CHIP) is a federal/state partnership that provides low-cost health coverage to children with low incomes yet too high to qualify for Medicaid. In some states, parents can also get health insurance through CHIP.

COBRA: When employees lose their job, they are able to continue their employer-sponsored coverage for up to 18 months due to the Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA. Usually, the former employee must pay the full cost of the premium, including the portion typically paid by the employer in order to continue this coverage. During the current recession, a temporary subsidy was put in place to help unemployed workers afford this coverage.

Coinsurance: The share of medical services paid by the patient, defined as a percent of the total cost. For example, in Medicare, patients are responsible for 20% coinsurance for many outpatient services.

Copays, Copayments: A fixed amount for each service paid at the time of service. Examples include payments for each physician visit or for each prescription filled.

Cost-Sharing: Cost sharing refers to the patient's portion of the charges for doctor visits, prescriptions and other types of services. Several benefit provisions determine the patient's share of these expenses: deductibles, coinsurance, copayments, and out-of-pocket limits.

Deductibles: The deductible is an amount that must be paid by the patient before the insurer will begin paying. For example, the covered individual has a \$50 deductible, he or she would have to pay the first \$50 of health care charges, after which the insurer would begin paying according to the terms of the policy.

Doughnut Hole: A gap in Medicare's prescription drug (Part D) coverage. In most Medicare drug plans, insurance coverage is suspended after drug costs for the year reach \$2,700, and enrollees are responsible for the next \$3,380 before coverage resumes. These amounts increase every year for inflation.

Electronic Medical Records: Comprehensive, computerized versions of the paper medical records most doctors now use. Establishing nationally recognized standards for such records would allow health care providers to record all of the patient's medical information—including test results, diagnoses, medications, drug allergies, and family history—and share them, electronically, with any other authorized provider, including doctors, nurses, hospitals, nursing homes, home-care providers, pharmacists, and social workers. Patients, too, would have access to such records. For more information: <http://blogs.consumerreports.org/health/2009/03/electronic-health-records.html>

Employer Coverage: Employers today are not required to offer health coverage to their workers. Nonetheless, many employers voluntarily choose to offer health coverage because it is convenient and cost-effective for their workers. Because workers have come to expect health insurance as part of their job, it would be difficult for many employers to attract qualified workers if they didn't offer this benefit. There are exceptions, of course. Certain industries that pay low wages or hire a lot of part-time workers may not offer health benefits.

Glossary of Health Reform Terms - continued

Federal Poverty Guidelines: These guidelines indicate the amount of income that represents the “poverty level” for a given family size. For example, in 2009, the poverty level for a single person was \$10,830 per year. For a family of three, a family income of \$18,310 would place the family at the poverty level (see Table below). The income level associated with the federal poverty level increases every year according to a formula used by the Federal government. “Multiples” of the federal poverty guidelines (like “133% of FPL”) are often used to define eligibility for various federal and state social benefit programs.

2009 Federal Poverty Guidelines

Family Size	Federal Poverty Level	133% of Federal Poverty Level	150% of Federal Poverty Level	400% of Federal Poverty Level
1	\$10,830	\$14,440	\$16,245	\$43,320
2	\$14,570	\$19,427	\$21,855	\$58,280
3	\$18,310	\$24,413	\$27,465	\$73,240
4	\$22,050	\$29,400	\$33,075	\$88,200
For each additional family member, add:	\$3,740	\$4,987	\$5,610	\$14,960

Source: <http://aspe.hhs.gov/poverty/09poverty.shtml>

Health Insurance Exchange: A Health Insurance Exchange is like a health insurance store. “Shoppers” can choose from among several health insurance options arrayed “side-by-side.” The Exchange may take on a variety of other duties including: establish health plan standards, enrollment, billing, and other administrative functions, administer coverage subsidies, and respond to consumer grievances.

High Deductible Health Plans: Health plans with deductibles of \$1,150 or more are often termed “high deductible health plans.” If these plans meet certain standards, they can be paired with Health Savings Accounts, which are funded (by an employer or the policyholder) with pre-tax dollars. With this arrangement, patients can pay their cost-sharing in a tax advantaged way or save these funds for future health expenses or even retirement. For more information:

<http://www.consumerreports.org/cro/aboutus/mission/viewpoint/falsepromisesconsumerdrivenhealthplans0605/>

High Risk Pool: Today, high-risk pools are health insurance plans organized by states that serve individuals who have been denied coverage (typically because they have a health condition) and don’t have access to other insurance through their employer, Medicare or Medicaid. In most states, the premium for this coverage is set somewhat above regular market rates. As a result, many who are otherwise eligible the high risk pool don’t enroll because they can’t afford it.

Individual Mandate: A requirement that each individual have health insurance. Exceptions are allowed, for example, religious objection or a lack of affordable options.

Legal Immigrants: Each state must decide whether or not to provide Medicaid coverage for legal immigrants who have resided in the United States for less than six years (same treatment as under current law). If states opt not to cover recent legal immigrants, these residents would be eligible to purchase coverage in the health insurance exchange. Legal immigrants who have been in the country six years or longer are eligible for Medicaid if they meet the program’s other requirements. Undocumented immigrants are not eligible for Medicaid or CHIP, nor can they get credits to purchase in the exchange, regardless of how long they have resided in the United States.

Medicaid: The Medicaid program is a federal/state partnership that provides health coverage for certain low-income persons. Under current law, each state determines the income level at which these groups qualify for Medicaid coverage. Usually, working age adults without dependent children do not have access to Medicaid coverage. For more information: <http://www.kff.org/medicaid/upload/Medicaid-A-Primer-pdf.pdf>

Glossary of Health Reform Terms - continued

Medical Loss Ratio: Across a large insured group, the proportion of the premiums spent on medical care (as opposed to profit or administration) is sometimes called the Medical Loss Ratio. Among large insured groups, such as large employers, the proportion of the premium spent on medical care could be as high as 95%. Among plans sold to individuals, the proportion is sometimes much lower--as low as 65%. While a single policyholder would not generally expect to receive care that is equal to what they paid in premiums, across all people with that coverage, the premiums charged should not be vastly different from the care consumed across the whole group.

Medicare: Medicare is a health insurance program, administered by the federal government, for people aged 65 and over, or who meet other special criteria. Medicare has two parts: **Part A (Hospital Insurance)** which helps pay for inpatient care you get in a hospital, skilled nursing facility, or hospice, and for home health care; and **Part B (Medical Insurance)** which helps pay for doctors' services and outpatient care. Prescription drugs are paid through an optional program called **Part D**.

Medicare Advantage Plans: Medicare Advantage is an alternative to "traditional" Medicare available in most parts of the country. The federal government pays insurance companies to run these alternative plans as a means of giving seniors more options. These private plans cover the same services as Medicare but use different cost-sharing arrangements. Because they receive a pretty generous payment from the government, these plans often include extra benefits like eyeglasses. They may also use "restricted" networks of providers, like an HMO. About 20 percent of the Medicare population is enrolled in these plans. Most enrollees in these plans don't know them as Medicare Advantage but as the name on their insurance card.

Medi-gap Coverage: Medi-gap coverage is optional coverage that fills in the "gaps" in Medicare like the inpatient hospital deductible. This coverage is regulated by the federal government but the policyholder bears the full cost.

Minimum Coverage Standards: Under the proposed reform bills, minimum standards for health coverage would be established. For example, the bills call for health plans to cover a comprehensive array of services such as inpatient hospital, outpatient hospital, doctors visits, lab, x-ray, prescription drugs, mental health services and maternity services. The plans could not have annual or life-time limits on benefits. Patient cost-sharing would be limited so that it doesn't exceed \$5,000 to \$6,000 a year (depending on the bill). Lower income families would have even greater protection from catastrophic medical bills. These standards would be used in order to determine whether or not an individual met the definition of being insured.

Pay or Play: a term which refers to the requirement of companies to offer health insurance to their employees or make a payment to the federal government to help pay for coverage of the uninsured.

Payment Bundling: a provider payment structure in which health care providers are paid for "episodes of care" rather than individual medical procedures. The aim is to improve care and reduce costs by providing doctors and hospitals with an incentive to reduce complications and unnecessary procedures.

Pre-Existing Conditions: A pre-existing condition is a health or medical problem an individual has before applying to be accepted into a health insurance plan.

Premiums: Premiums are the "price" charged for health insurance. They are typically charged at regular intervals, such as monthly, and generally the same amount is charged each time.

Primary Care Providers: These are the doctors, nurse practitioners and physician assistants who provide primary medical care like routine physicals, vaccinations, and treatments for everyday illnesses like colds and flu. Under reform, there would be new roles for primary care providers, such as coordinating their patient's care across various specialists and settings. New payment systems would ensure that primary care providers are reimbursed for these tasks, in an effort to ensure that the supply of providers is adequate.

The Public Insurance Plan Option: A proposed government-sponsored health insurance plan that would compete with private insurance plans. The public plan would offer quality, comprehensive coverage and be subject to the same rules as private insurers. Once up and running, plan operations would be paid out of premium revenue, not taxpayer funds. In the Senate bill, this plan is called **Community Health Insurance Option**.

SCHIP: The State Children's Health Insurance Program (SCHIP) became known as CHIP when the program was reauthorized in 2009. See CHIP.

More Resources From Consumers Union

On our website, you can find additional materials on the topic of National Health Care Reform.

On www.PrescriptionforChange.org, you'll find backgrounders on:

The Public Health Insurance Plan

What does it mean to have insurance as good as Congress gets?

Simplifying Health Insurance Choices for Consumers

You'll also find information on our work, including:

Consumers Union's "Prescription for Change"

Congressional Testimony

Consumers Union in the news

Stories we've collected from people who need reform

Information on how YOU can get involved

Note: This document was revised to incorporate the manager's amendment to the Senate bill, passed December 24, 2009.

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