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# U.S. Health-care Reform: The Patient Protection and Affordable Care Act

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**Abstract**

This short article provides an overview of the Patient Protection and Affordable Care Act, which was approved by the U.S. Congress and signed by President Barack Obama in March 2010, with an emphasis on provisions related to the expansion of health insurance. It highlights key provisions concerning coverage expansion, insurance market reforms, and the projected costs and financing of the legislation.

## Introduction

The U.S. House of Representatives approved the Patient Protection and Affordable Care Act (PPACA) on March 21, 2010 by a 219–212 vote with no Republican support. The Senate had previously passed the bill on December 24, 2009 by a 60–39 vote with no Republican support. Shortly after approving the PPACA, the House passed a package of amendments in the Health Care and Education Reconciliation Act of 2010, which, with a few minor changes, was approved by the Senate (56–43) and again by the House (220–207) on March 25. President Obama signed the original PPACA on March 23 and the final reconciliation bill on March 30, 2010, completing the most significant social legislation in the United States since the enactment of Medicare and Medicaid in 1965.

This short article provides an overview of the PPACA, as amended, with an emphasis on provisions dealing with health insurance. It highlights the law's key provisions concerning coverage expansion, insurance market reforms, and the projected costs and financing of coverage expansion. It serves as an addendum to my article (Harrington, 2010) dealing with earlier U.S. House and Senate health-care reform bills. Although the details vary in some significant ways from those bills (e.g., the absence of a public option and the inclusion of a Medicare tax on unearned income—see below), the structure of the new law is similar, and most of the discussion in that article remains applicable.

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## COVERAGE EXPANSION

Table 1 highlights key insurance-related and financing provisions of the new law.[1] The law will expand health insurance coverage primarily by (1) requiring individuals to obtain qualified health insurance, (2) subsidizing the cost of coverage for low- to moderate-income persons, (3) requiring other than small employers to offer health coverage to employees, and (4) significantly expanding eligibility for Medicaid.

Beginning in 2014, most legal residents will be required to have health insurance that meets minimum requirements, unless the cost of minimum qualified coverage exceeds 8 percent of their income. The penalty for noncompliance with the "individual mandate" will be the greater of $95 or 1 percent of taxable income in 2014, increasing to the greater of $695 or 2.5 percent of taxable income in 2016, and indexed to inflation in later years.[2] Premium credits (subsidies) will be provided to individuals/families with income between 133 and 400 percent of the federal poverty level (FPL). The credits will limit premium contributions to specified percentages of income (e.g., 3–4 percent for incomes between 133 and 150 percent of FPL, increasing to 9.5 percent for incomes between 350 and 400 percent of FPL). The law also reduces cost sharing for persons with incomes up to 400 percent of FPL, with greater reductions for lower income individuals/families.[3] Eligibility for the taxpayer-funded Medicaid program will be expanded to people with incomes up to 133 percent of the FPL and will include nondisabled, nonelderly adults without dependent children.

Apart from establishments with fewer than 50 employees, businesses will have to offer health coverage to employees or pay a penalty. Businesses with 50 or more employees that offer coverage to employees will pay a penalty if one or more of their employees obtain subsidized coverage outside of employment. Employers with 25 or fewer employees and with annual wages averaging less than $50,000 will be eligible for tax credits for offering coverage.

The Congressional Budget Office (CBO) projects that the coverage expansion provisions of the law will result in 32 million fewer people being uninsured in 2019 (CBO, 2010a), with 16 million of the newly insured receiving coverage by Medicaid or the Children's Health Insurance Program. The CBO projects that 3 million fewer people will be covered by employer-sponsored health insurance in 2019 than under prereform law.

## INSURANCE MARKET REFORMS

The reform law promulgates the establishment of state-based health insurance exchanges for the individual and small-group markets. States are permitted to join compacts to establish multistate exchanges. Insurers participating in the exchanges and those offering coverage outside of an exchange will be restricted to offering four coverage tiers, along with a catastrophic plan for young adults. Health insurers will have to accept all applicants regardless of health status, without excluding coverage for preexisting conditions. Premium rates will be allowed to vary only by coverage

[1] See Kaiser Family Foundation (2010) for a detailed summary.
[2] The CBO (2010b) projects that about 4 million nonelderly people will pay penalties in 2016 of a total of 21 million people projected to be uninsured (including unauthorized immigrants).
[3] The CBO projects an average premium subsidy of $6,000 annually by 2019 (CBO, 2010a).

**TABLE 1**
The Patient Protection and Affordable Care Act (as Amended)

| Item | Description |
|---|---|
| Individual mandate | Beginning in 2014 if cost no more than 8% of income; noncompliance penalty of the greater of $95 or 1% of taxable income in 2014 increasing to the greater of $695 or 2.5% of taxable income in 2016. |
| Employer mandate | Employers with 50 or more employees not offering coverage with one or more employees receiving a premium credit (subsidy) pay fee of $2000 per employee, excluding first 30 employees; employers with 50 or more employees that offer coverage with one or more employees receiving premium tax credit pay specified fees. |
| Medicaid expansion | Eligible with income up to 133% of FPL. |
| Premium and cost-sharing subsidies | Premium credits and reduced cost-sharing credits for individuals and families with incomes up to 400% of FPL. |
| Small business tax credits | Employers with 25 or fewer employees and average annual wages less than $50,000 eligible for tax credits for offering coverage. |
| Qualifying coverage | Broad categories of services; four cost-sharing tiers (bronze, silver, gold, and platinum); catastrophic plan for people up to age 30. |
| Grandfathering of existing plans | Grandfather existing plans with respect to new benefit standards; require existing plans to (1) prohibit preexisting conditions clauses for children and later adults, (2) extend dependent coverage to adult children up to age 26, (3) eliminate annual or lifetime benefit limits, (4) eliminate waiting periods greater than 90 days, and (5) prohibit rescissions absent fraud. |
| Insurance market reforms | State-level health insurance exchanges with option for states to join compacts; guaranteed issue without preexisting condition exclusions or rates based on health status; 3-to-1 age rating band; risk adjustment; temporary high-risk pool (2010); require health plans to report medical loss ratios (2010) and provide rebates if less than 85% for large groups and 80% for individuals and small groups (2011); establish process for reviewing rate increases (2010). |
| Public plan/co-ops | No public plan; creates the Consumer Operated and Oriented Plan program to promote the creation of nonprofit, member-controlled health plans at the state level. |
| Antitrust | No provision. |
| Long-term care | Establish voluntary program for purchasing Community Living Assistance Services and Supports (CLASS program) to provide cash benefits to enrolled workers after 5-year vesting period; payroll deduction with automatic enrollment unless opt out. |
| Projected coverage | 94% of nonelderly legal residents; 92% of all residents. |

(*Continued*)

**TABLE 1**
Continued

| Item | Description |
|---|---|
| Projected 10-year cost of expanded coverage | $820 billion ($358 billion exchange subsidies; $434 Medicaid/CHIP expansion; $37 billion small employer tax credits), exclusive of spending subject to future appropriations. |
| Projected taxes and fees | $438 billion, including $210 billion additional Medicare taxes; $32 billion from 40% excise taxes on high-cost plans (beginning in 2018 for individual coverage with annual value above $10,200 and family coverage above $27,500; thresholds indexed to CPI beginning in 2020); $65 billion in individual and employer penalties; $27 billion tax on branded drug companies, $20 billion tax on device companies, $60 billion tax on health insurers. |
| Projected spending reductions | $455 billion, primarily from Medicare, including $136 billion from Medicare Advantage. |
| Projected deficit impact | −$143 billion (−$70 billion from CLASS program). |

*Sources*: The Patient Protection and Affordable Care Act, Congressional Budget Office (2010a), Joint Committee on Taxation (2010), and Kaiser Family Foundation (2010).

tier, number of dependents, geographic region, age (within 3:1 ratio), and tobacco use (1.5:1 ratio).

Beginning in 2011, the law specifies that health insurers must spend an amount on medical costs equal to a minimum of 85 percent of premiums for large-group coverage and 80 percent of premiums for small-group coverage, with insurers required to pay rebates to policyholders if required to achieve those minimums.[4] The law also requires establishment of a process for reviewing health insurance rate increases and for requiring plans to justify rate increases. A newly created Office of Consumer Information and Oversight will assist the states in reviewing rates. The law does not provide the federal government with the authority to regulate rates or require prior approval of rates by the states.

The reform law requires a variety of insurance market changes to become effective during 2010 or 2011, including (1) creation of temporary high-risk pools to provide subsidized coverage to individuals with preexisting medical conditions who have been uninsured for at least 6 months, (2) prohibition of preexisting condition exclusions for children, (3) extension of coverage to adult children up to age 26, (4) regulation of annual and lifetime benefit limits prior to their elimination in 2014, and (5) prohibition of policy rescissions absent fraud. Existing health plans are grandfathered with respect to the law's new benefit standards with a number of exceptions, including the prohibition of preexisting condition exclusions for children (and later for adults), the extension of dependent coverage to children up to age of 26, and the regulation and ultimate elimination of annual and lifetime benefit limits.

[4] The definition of eligible costs for calculation of the ratio is being debated by insurers and regulators.

In contrast to the House and Senate proposals discussed in my earlier article, the health-care reform bill approved by the full Senate in December 2009 and the final law do not establish a government health insurer to compete with private insurers (the so-called "public option"). Like the earlier bills, the final law authorizes and includes funds to subsidize the creation of nonprofit, co-operative health insurers at the state level.

## PROJECTED COSTS AND FINANCING

The CBO projects a 10-year cost of coverage expansion of $820 billion (excluding a variety of expenditures for administering and implementing the law that are subject to future congressional appropriations). That cost is roughly divided between the cost of premium subsidies and Medicaid expansion (see Table 1). The CBO projects over 10 years $438 billion in revenue increases from a variety of taxes and fees, and $455 billion in spending reductions, primarily for Medicare.

A significant change from the earlier House and Senate bills is the addition of a Medicare tax (Unearned Income Medicare Contribution) equal to 3.8 percent of investment income for taxpayers with adjusted gross incomes above $200,000 for individuals and $250,000 for joint filers. Along with an additional 0.9 percent Medicare Part A tax on earned income above $200,000 for individuals and $250,000 for joint filers, this tax is projected to generate $210 billion during 2012–2019 (Joint Committee on Taxation, 2010). The projected Medicare spending reductions over 10 years include $196 billion in projected cuts in annual updates to hospital reimbursement rates and $136 billion in projected cuts in Medicare Advantage reimbursement (CBO, 2010a). The law also establishes an Independent Payment Advisory Commission to recommend additional cuts in Medicare spending if per capita growth in Medicare spending exceeds target levels.

The CBO projects that the law will reduce federal deficits by $143 billion over 10 years. That amount includes $70 billion in projected deficit reduction from creation of a voluntary, employment related long-term care insurance program, the Community Living Assistance and Support Services (CLASS) program. This program is projected to generate substantial revenues and minimal costs over the next 10 years. It is projected to produce offsetting costs in excess of revenues in later years.

## CONCLUSION

Assuming that its key provisions take effect, the PPACA will significantly expand health insurance coverage in the United States through its individual mandate, premium subsidies, and expanded eligibility for Medicaid. The law will transform private health insurance markets through its creation of state-level exchanges and federal government prescription of individual and small-group health insurance benefits, coverage, and allowable underwriting/rating criteria.

The health-care reform legislation remains controversial. As of May 2010, attorneys general in 20 states had joined a lawsuit challenging the constitutionality of the individual mandate. Nearly 40 state legislatures had introduced some form of legislation to challenge or interfere with the law's implementation (National Conference of State Legislatures, 2010). The law's major provisions are not scheduled to become effective until 2014, following congressional elections in 2010 and 2012 and the presidential

election in 2012. Many Republican members of Congress (and potential candidates for office) advocate repeal of the law's key provisions and enactment of market-oriented reforms.

The benefits and costs of coverage expansion notwithstanding, substantial skepticism exists over whether the health-care reform law will significantly slow the growth in health-care costs (i.e., "bend the cost curve") or dent federal health-care spending deficits. The Office of the Actuary of the Center for Medicare and Medicaid Services projects that that law will increase total health-care spending by $311 billion over 10 years due to greater utilization of health-care services (Office of the Actuary, 2010). Projected Medicare spending cuts and new Medicare taxes will largely be used to fund coverage expansion, as opposed to reducing the federal health-care deficit. The cost of health care and insurance will likely remain problematic in the United States for the foreseeable future.

## REFERENCES

Congressional Budget Office, 2010a, H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation) March 20. World Wide Web: http://www.cbo.gov/doc.cfm?index=11379.

Congressional Budget Office, 2010b, Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act April 22. World Wide Web: http://www.cbo.gov/ftpdocs/113xx/doc11355/Individual_Mandate_Penalties-04-22.pdf.

Harrington, S. E., 2010, The Health Insurance Reform Debate, *Journal of Risk and Insurance*, 77: 5-38.

Kaiser Family Foundation, 2010, Focus on Health Reform—Summary of New Health Reform Law, April 21. World Wide Web: http://www.kff.org/healthreform/upload/8061.pdf.

Joint Committee on Taxation, 2010, Estimated Revenue Effects of the Amendment in the Nature of a Substitute to H.R. 4872, The "Reconciliation Act of 2010," as Amended, in Combination With the Revenue Effects of H.R. 3590, The "Patient Protection and Affordable Care Act," March 20. World Wide Web: http://www.jct.gov/publications.html?func=showdown&id=3672.

Office of the Actuary, 2010, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended, U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services, April 22. World Wide Web: http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

National Conference of State Legislators, 2010, State Legislation Challenging Certain Health Reforms, May 21. World Wide Web: http://www.ncsl.org/?tabid=18906.