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.

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 various 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).

Overview of Coverage Options Under House Reform Bill

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Overview of Coverage Options Under the House Health Reform Proposal

**Do You Have Employer Provided Insurance?**
- Yes (159 million) → Coverage Continues
- No
  **Are you enrolled in Medicare or Medicaid (or eligible to enroll now)?**
  - Yes (86 million) → Coverage Continues
  - No Insurance or has an individual policy
    **How Much Money Does Your Family Earn?**
    - More than 400% of poverty line\(^1\)
      (13 million) → New insurance choices in the exchange (unsubsidized)
    - 133%-400% of poverty line\(^2\)
      (20 million)
    - Less than 133% of poverty line\(^3\)
      (9 million) → New Coverage Under the Medicaid Expansion

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\(^1\) 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.
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 annual premium toward his share of the policy.

Under proposed health reform bills

CHOICES

- The Taylors can keep the coverage they have now. Randy’s employer will be required to continue offering health coverage to employees and contribute a certain amount toward the family’s premium, or a pay a penalty. Currently, employers are not required to offer coverage to workers.

- The Taylors would have a guaranteed level of benefits. Eventually, all employer-based health coverage will have to meet certain standards, including preventive care, hospitalization, prescription drugs, etc. Most large companies’ current health plans already meet these standards.

COST

- The Taylors will continue to benefit from the financial security of having a good, comprehensive health insurance policy.

- As more uninsured get covered, Randy and his employer won’t have to pick up the cost of the uninsured’s care. Today, unreimbursed health care costs for the uninsured adds about $1,000 to the annual family premium.

- Efforts to lower health costs, such as electronic medical records and paying doctors and hospitals based on the quality of care, not how much care they give, will also benefit the Taylors’ pocketbook.

DIFFERENCES

House Bill (as of July 31):

- Most employers must pay at least 72.5% of the premium for single coverage, and 65% for family coverage. Employers may make higher contributions if they choose.

- Alternatively, 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.

Senate HELP Committee (as of July 15):

- Most employers must pay at least 60% of the premium for single coverage for a full-time worker.

- Alternatively, employers who don’t offer coverage must pay $750 for each full-time employee, and $375 for each part-time worker into a fund that helps those purchasing coverage in the exchange.
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. His company would have to pay a certain amount of Frank's premium (or else pay a penalty), and eventually offer coverage that meets minimum standards. However, high-deductible plans such as Frank's could meet that standard.

- Or, Frank could get coverage on his own through a new health insurance "store" or exchange with a variety of choices, including a new public insurance plan option. Since Frank's job offers him coverage now that meets required standards, he wouldn't get financial help to buy a policy in the exchange. But, should Frank lose his job, the exchange would serve as an important safety net, as he would then qualify for subsidies that will help him afford 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's insurance from his job meets the minimum standards, his costs may stay about the same. But as more of uninsured get covered, their costs will no longer be embedded in the premiums that people like Frank pay.

DIFFERENCES

House bill (as of July 31, 2009):

- Frank’s employer would have to cover at least 72.5 percent of his individual premium or pay into a fund that helps cover low-income families in the exchange.
- He could get financial help to buy a policy in the exchange if the cost of his employer coverage exceeds 11%-12% of his income and he makes less than “400% of poverty.”

Senate HELP Committee bill (as of July 15, 2009):

- Under this bill, his employer would have to cover at least 60 percent of his premium or pay into a fund that helps cover low-income families in the exchange.
- Financial help for a policy in the exchange is available if the cost of his employer coverage exceeds 12.5% of his income and he makes less than “400% of poverty.”
How Health Reform would affect:

Penelope: small-business owner struggling to cover her employees

Penelope, 48, graphic design shop owner, 8 employees with annual payroll of $360,000. Provides coverage for workers but premiums have increased 10% each year; now offers only high-deductible coverage ($5,000). Penelope is a breast-cancer survivor.

Under proposed health reform bills:

CHOICES

- 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 including a new public insurance plan option. Penelope can contribute a fixed amount to her employees’ coverage and then let them pick the plan that suits them best, and they would pay the balance of their premiums.

- Small businesses would also have the option of purchasing coverage outside the exchange. Those insurers will have to follow the same rules as insurers in the exchange.

- Eventually, the coverage Penelope offers her workers would have to meet new, minimum standards for coverage. Although Penelope is not obligated to offer coverage at all, if offered, the coverage would have to feature lower deductibles.

COSTS

- Both Penelope and her employees may see their premium increases moderate over time as competition increases among plans in the exchange.

- New rules determine how premiums are set. Among other things, insurers cannot charge more due to pre-existing conditions.

- Depending on the legislation, Penelope’s business may be eligible for tax credits to help her pay the cost of her workers’ coverage (and her coverage, depending on her net income).

DIFFERENCES

House bill (as of July 31, 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.

- A small business could qualify for a tax credit to cover part of the costs if the average salary paid per employee doesn't exceed $40,000 and the business has fewer than 25 employees.

Senate bill (as of July 15, 2009):

- Businesses with 25 or more employees would either have to offer coverage to workers, or pay into a fund. With just 8 employees, Penelope would be exempt from this requirement.

- A small business could qualify for a tax credit if the average salary paid per employee doesn’t exceed $50,000 and the business has 50 or fewer employees. The tax credits would be worth up to $1,000 for single coverage and $2,000 for family coverage.
How Health Reform would affect:

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

Bernie, 35, would love to quit his carpentry 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, featuring private coverage options and the choice of a new public insurance plan.
- 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 for individuals through the exchange, depending on how much they make.
- They also might qualify for new tax credits for small businesses and self-employed persons who buy their own coverage.
- The couple may see annual premium increases moderate over time as insurance plans compete for customers in the exchange. They will benefit from other efforts to lower health costs, such as electronic medical records and paying doctors and hospitals based on the quality of care, not how much care they give.

DIFFERENCES

House bill (as of July 31):

- If they strikeout on their own, the couple may qualify for credits that lower the cost of coverage in the exchange (depending on their income).
- Self-employed individuals with no employees may qualify for tax credits to help small employers buy coverage in the exchange, depending on how much they make from their business.

Senate HELP Committee bill (as of July 15):

- If they strikeout on their own, the couple may qualify for credits that lower the cost of coverage for individuals in the exchange (depending on their income).
- As long as they aren’t already receiving individual “credits” to purchase coverage, the self-employed may qualify as a business for tax credits worth up to $1,000 for single coverage and $2,000 for family coverage. To qualify, a self-employed person must make less than $50,000 from their business.
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 ($3,000) 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 new choices in a new "store" called the health insurance exchange, which includes a public health insurance plan along with private insurance plans.
- 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.
- Enrique can 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 that require everyone get coverage and determine how premiums are set, should also even out those increases, as more people come into the insurance “pool.”
- At his income, Enrique would not qualify for the new credits designed to lower health insurance costs for individuals, the self-employed and small businesses.

DIFFERENCES

House bill (as of July 31, 2009):

- Individuals could not buy coverage outside the exchange, except for “grandfathered” coverage that was already in place (like Enrique’s coverage).

Senate bill (as of July 15, 2009):

- Enrique could still buy an individual policy outside the health insurance exchange.
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 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. States will 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.
- Since Len is eligible for Medicaid, he cannot buy a policy in the exchange on his own. But he can get coverage in the exchange if it is through his employer. His employer also has the option of offering coverage outside the exchange.

**COSTS**

- The Green’s cost for Medicaid coverage will likely continue to have low premiums or non-existent premiums.
- If Len’s employer offers coverage through the exchange, Len’s cost could be 35% to 40% of the policy, 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 (as of July 31, 2009):**

- Initially, employers with fewer than 15 workers can offer coverage through the exchange. Larger employers would be eligible to participate in later years.
- Small employers that offer coverage can get a tax credit of up to 50% of the cost, as long as they have less than 25 workers, an average wage of less than $40,000 and pay at least 72.5% percent of their worker’s premium.
- Small employers with annual total payroll under $500,000 are exempt from the new requirement to offer coverage or pay penalties.

**Senate bill (as of July 15, 2009):**

- Employers with fewer than 51 workers are allowed to offer coverage through the exchange.
- Small employers that offer coverage can get a tax credit of $1,000 for each employee with single coverage ($2,000 for family coverage) if the company has an average wage of less than $50,000 and pays at least 60% of employees’ premiums.
- Employers with fewer than 25 workers are exempt from the new requirement to offer coverage or pay penalties.
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. Kids get coverage through her state’s children health insurance program (CHIP). She pays $10 a month per child and low co-pays.

**Under proposed health reform bills:**

**CHOICES**

- Beth’s employer could decide to pay a larger portion of the cost of her health insurance premium. Otherwise, her employer would have to pay into a fund that helps cover lower-income individuals like Beth in the exchange.

- If her employer doesn’t increase their premium payment, Beth could get coverage for herself or her whole family through a new health insurance “store” or exchange with a variety of choices, including a new public insurance plan option.

- Depending on the bill, CHIP coverage for Beth’s kids would either continue or be replaced by a different option in the exchange.

- Beth would have to get coverage unless she can show she can’t afford it.

**COST**

- Since Beth’s employer has an incentive to pay more of her premium, she may find she can now afford her employer’s coverage. She might pay 27.5% to 40% of the cost, depending on the bill and whether she includes her kids on the policy.

- If the cost of employer coverage remains very high, Beth would qualify for significant financial help purchasing a policy in the exchange. At her income, she would be expected to pay around 4% of her income (about $1,500 a year) for her coverage in the exchange.

**DIFFERENCES**

**House bill (as of July 31, 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.

- To get help paying for her coverage in the exchange, Beth’s cost for her share of her employer coverage must exceed 11-12% of her income. Otherwise, people with employer coverage are not eligible for subsidies (“credits”) in the exchange.

- The CHIP program for low-income children would go away once affordable, comparable coverage is available in the exchange.

**Senate HELP bill (as of July 15, 2009):**

- Her employer would pay at least 60% of Beth’s individual or 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 the cost for her employer coverage exceeds 12.5% of her income. Otherwise, people with employer coverage are not eligible for subsidies in the exchange.

- CHIP coverage still available to low-income children.
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.

- Under one bill, he could remain on his parent’s health coverage until age 26.

- Because he’s Medicaid-eligible, Vince couldn’t buy coverage in the new health exchange. If his income increases so he no longer qualifies for Medicaid, he could be eligible for the exchange.

- 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.

DIFFERENCES

House bill (as of July 31):

- To qualify for Medicaid, individuals can make no more than $14,500 per year. Larger families could have higher income levels and still qualify.

Senate HELP bill (as of July 15):

- In this bill, someone can make a bit more and get Medicaid -- $16,200 for an individual. Larger families could have higher income levels and still qualify.

- Allows young adults to stay on their parents’ coverage until age 26.
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, with a variety of plans including a public insurance plan option.

- Under one of the bills, 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.

- 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 poverty level, Mia would get help paying for coverage purchased through the exchange. At her income, she would be expected to pay a little more than 4% of her income (about $875 a year).

- In the exchange, the costs for medical services would also be limited to amounts affordable for Mia.

DIFFERENCES

House bill (as of July 31, 2009):

- Individuals couldn’t buy coverage outside the insurance exchange.

Senate HELP Committee bill (as of July 15, 2009):

- Mia would have the option of buying a policy outside of the exchange, but if she did, she could not get help (credits) paying for this coverage.

- Even outside the exchange, insurers would still be subject to rules that prohibit them from denying coverage or charging higher premiums.
How Health Reform would affect:

Brian: Disabled and Uninsured

Brian, 39 and divorced, was in an accident six months ago that left him 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 the disabled 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 are different under the two bills.
- Under one bill, Brian could enroll in a broadened Medicaid program. This coverage may be more comprehensive than what he is waiting to get under Medicare.
- The same bill also gives Brian the option of buying health insurance on his own but he won’t get any financial help to purchase this coverage.
- 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 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 is likely to be cheaper than the coverage he’s waiting for under Medicare.
- Under the other bill, Brian would get substantial help paying for his coverage in the exchange. He would be expected to pay about 3% of his income (about $480 a year). His costs for medical services would also be affordable.

DIFFERENCES

House bill (as of July 31):
- Brian wouldn’t qualify for Medicaid because individuals can make no more than $14,500 per year. Larger families could have higher income levels and still qualify.
- At his income, Brian qualifies for credits to help purchase coverage in the exchange.
- Individuals couldn’t buy coverage outside the insurance exchange.

Senate HELP bill (as of July 15):
- In this bill, someone can make a bit more and get Medicaid—$16,200 for an individual. Larger families could have higher income levels and still qualify. Medicaid eligibility makes Brian ineligible for credits in the exchange.
- Brian would have the option of buying a policy outside of the exchange. He could not get help (credits) paying for this coverage.
- Even outside the exchange, insurers would still be subject to rules that prohibit them from denying coverage or charging higher premiums.
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 for preventive services like physicals, mammograms, glaucoma screening and other services as they do now.
- They could have better choices of primary care doctors because those types of health care providers will get paid more.
- 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 cost of many medicines in the doughnut hole will be lower.
- Money-saving measures and efforts to reduce fraud and waste and overpayments strengthen the long-term financial health of Medicare so it doesn’t “run out of money.”

DIFFERENCES

- To date, only the House bill addresses the Medicare program because the Senate Finance Committee, which has jurisdiction over Medicare in the Senate, has yet to pass their bill out of committee.
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 either type of coverage will be sustainable in the future.

• Under either program, the couple won’t have to pay for preventive services like physicals, mammograms, glaucoma screening and other services.

DIFFERENCES

• To date, only the House bill addresses the Medicare program because the Senate Finance Committee, which has jurisdiction over Medicare, has yet to pass their bill out of committee.
Passing Health Reform: The Legislative Steps

Congress hasn’t passed any bills yet although they hope to do so in the fall. Several House and Senate committees have jurisdiction over the various parts of our healthcare system. As the chart below shows, these various committees, and then the House and Senate, will need to reconcile their differences with respect to the proposed health reform legislation. As a result, the final legislation will undoubtedly differ from the proposed legislation described in this document.

As changes are proposed, Consumers Union will update the descriptions of the impact on our 12 fictional families.

The process stands here

**House**: The three house committees have approved a consolidated bill. The legislative language available doesn’t yet incorporate many of their accepted amendments. In addition, they are considering a final set of amendments.

**Senate**: The Senate HELP committee has released a bill which doesn’t yet incorporate many accepted amendments. The Senate Finance committee is still working on their bill.

Source for chart: National Women’s Law Center, 2009
<table>
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<tr>
<th>Summary of the New Proposals</th>
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<tr>
<td><strong>House bill (as of July 31)</strong></td>
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<tr>
<td><strong>Individual Mandate</strong></td>
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<tr>
<td><strong>Everyone must enroll in health coverage or face a penalty equal to 2.5% of their income (the penalty can’t exceed the cost of the coverage itself). A person is exempted from the penalty if they can demonstrate there’s no insurance option they can afford.</strong></td>
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<tr>
<td><strong>New Health Insurance Store</strong></td>
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<tr>
<td>For those without a &quot;qualified&quot; 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.</td>
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<tr>
<td><strong>Medicaid Eligibility</strong></td>
</tr>
<tr>
<td><strong>Medicaid is expanded</strong> to include all low-income people (citizens and legal immigrants) who make less than 150% of the federal poverty level – about $16,200 for individuals and $22,000 for couples. Larger families could have higher income levels under and still qualify for Medicaid. States would be required to maintain Medicaid eligibility standards currently in place.</td>
</tr>
<tr>
<td><strong>Changes to CHIP</strong></td>
</tr>
<tr>
<td>The State Children’s Health Insurance Program would be eliminated once coverage through the exchange becomes available and it is determined to be as generous as the coverage now available in CHIP.</td>
</tr>
<tr>
<td><strong>New Rules for Insurance Companies</strong></td>
</tr>
<tr>
<td>Insurers can no longer deny coverage based on someone’s pre-existing medical condition. 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. 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.</td>
</tr>
<tr>
<td><strong>Help Paying for Coverage</strong></td>
</tr>
<tr>
<td>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. That means financial help is available on a sliding scale for single person who makes less than $43,000 a year – the less they make, the more help they can get. Larger families are eligible at higher income levels. If they have other qualified coverage (like employer coverage), they are not eligible for this help, unless the cost of that employer coverage exceeds 11-12% of income (to be determined).</td>
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### Employer Incentives to Cover Workers

**House bill (as of July 31)**

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.

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, such as preventive care, hospitalization, prescriptions, etc. Most companies’ current health plans would meet the standards. Smaller employers with a total payroll less than $500,000, are exempted.

**Senate HELP bill (as of July 15)**

Employers with more than 25 workers would face new incentives to offer health coverage, including part-timers.

These employers must offer coverage and contribute at least 60% of the premium cost OR pay $750 for each uninsured, full-time employee, and $375 for each uninsured part-time employee who is not offered coverage. For employers subject to the assessment, the first 25 workers are exempt.

### COBRA

COBRA coverage would continue.

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.

COBRA would continue under this bill, without changes.

### Special Rules for Small Employers

**In the first year of operation, very small employers (under 15 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). Larger employers may be able to participate in later years.

Employees who purchase in the exchange through their employers are not eligible for the affordability credits that individuals who buy in the exchange can apply for.

Very small employers with low-wage employees can 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 cost of coverage. The size of the credit declines as employer size goes above 10 employees and average wage goes above $20,000.

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.

Employers with 50 employees or less may offer the gateway coverage to their employees.

Employees who purchase in the gateway through their employers are not eligible for the affordability credits that individuals who buy in the exchange can apply for.

**Beginning in 2010,** employers with fewer than 51 workers could get tax credits to help defray the cost. To qualify, their average wage must be less than $50,000 per year and they must pay more than 60 percent of their employees’ health insurance premiums. The maximum credit is $1,000 for each employee in single coverage and $2,000 for each employee in family coverage. The credits are available for no more than three consecutive years.

Employers with less than 25 workers 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.
### Medicare

Beginning in 2011, the Part D coverage gap known as the “doughnut hole” will begin being phased out, so by 2023 the gap disappears. During this phase out, seniors who fall into the doughnut hole will get discounts of 50% for brand-name drugs.

Also beginning in 2011, 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.

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.

Provides new funding for research into treatments for chronic diseases that affect many elderly Americans.

Attempts to cut waste and end overpayments to insurance companies to strengthen the long-term financial health of Medicare. For example, it strengthens Medicare payment accuracy and provides incentives to improving care for seniors treated in the hospital so they are not rehospitalized.

### Medicare Advantage Plans

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.

Prohibits Medicare Advantage plans from charging cost-sharing for specific services (like home health) that exceeds the cost-sharing in traditional Medicare.

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.

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The Medicare program falls under the jurisdiction of the Senate Finance Committee. This committee has not yet released a bill.
# Health Reform Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>House Bill (as of July 31):</th>
</tr>
</thead>
</table>
| 2010 (Year One) | • Ends “rescissions” - health insurance companies can no longer drop expensive policies as a way of controlling costs.  
• Improves preventive health coverage in Medicare and Medicaid.  
• Increases reimbursement for primary care in Medicaid.  
• Provides for 12-month continuous eligibility in CHIP. |
| 2011 (Year Two)   | • Requires health plans to meet minimum “medical loss ratio” standards.  
• Begins to fill in the Medicare part D drug “doughnut hole” |
| 2013 (Year Four) | • Prohibit 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.  
• Health Insurance Exchange Begins. Individuals and Firms under size 15 can enroll.  
• Public Health Insurance Option is created  
• Affordability credits begin - available to people with incomes above Medicaid eligibility and below 400% of poverty.  
• Requirement that individuals have health insurance begins.  
• Employer requirements begin - employers are required to offer coverage to their workers and families; otherwise must pay 8% of their payroll to help offset the cost of their workers coverage through the exchange. There are exceptions for small businesses. |
| 2014 (Year Five) | • Health Insurance Exchange expands to small businesses with up to 25 employees |
| 2018 (Year Nine) | • Employers outside the exchange are required to meet essential benefits package standards. |
| 2023 (Year 14)  | • Medicare Prescription Drug “doughnut hole” eliminated. |

Note: The Senate bill does not yet include a detailed implementation schedule.
**Affordability Credits**: These credits would help lower the cost of coverage purchased through the exchange or gateway. 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.
**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.

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


**Health Benefits Gateway:** A Health Benefits Gateway is the term used in the Senate HELP committee language for Health Insurance Exchange concept.

**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. The Senate HELP bill calls this a Health Benefits Gateway.

**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/](http://www.consumerreports.org/cro/aboutus/mission/viewpoint/falsepromisesconsumerdrivenhealthplans0605/)

**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](http://www.kff.org/medicaid/upload/Medicaid-A-Primer-pdf.pdf)

**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. For more info: [http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf](http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf)
Glossary of Health Reform Terms - continued

**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:** A 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. Once up and running, plan operations would be paid out of premium revenue, not taxpayer funds. In the Senate HELP 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