The Affordable Care Act: What does it mean for the average American?

Given that the Affordable Care Act has been at the forefront of the political fight between President Obama and his Congressional opponents as well as a major issue in the 2012 presidential campaign, you probably think that everything that could be said about it has been said multiple times. But many remain confused about what the law will do, when it will do it, and who stands to benefit.

First off, this legislation is only the beginning of reform, not the end. A product of political compromise, the Affordable Care Act (ACA) makes health insurance more secure and easier to maintain for many, and provides the most thorough and systematic approach to rein in costs and promote prevention, wellness, and quality that our country has ever attempted. But as written, ACA won’t solve all of our challenges even when its 10-year implementation is complete. We’ll need to see how it works and make changes as needed. But to make the law more understandable, we’ve broken the subject down in terms of how people benefit.

I have private insurance – do I benefit?

ACA will make your current coverage more secure in the face of catastrophe, and prevents the cherry picking that leaves many high-needs patients uninsured.

Since 2010, young adults may stay on their parents’ plans until the age of 26, and children cannot be denied coverage or care due to a pre-existing condition. Rescissions – the cancellation of an insurance policy when an insured client develops a costly condition such as cancer or HIV – are no longer allowed. The law prohibits annual limits on insurance plan payouts, and requires companies to provide preventive care without co-pays.

In 2014, more reforms come into play: Insurance companies may not set lifetime maximum limits, or charge different prices based on gender, employment type, or health history. They will also be restricted as to how much they can charge based on age.

For years, the health insurance industry’s goal has been to reduce the ratio of each dollar of income (premiums) to what is spent on care. But since 2011, insurance plans must spend at least 80 percent of premiums on medical care payments, or rebate what they should have spent on care. Yes, rebate checks will be on their way to some customers this summer.

What about people without insurance?

ACA expands coverage in two ways: through Medicaid and the establishment of health insurance exchanges. Medicaid eligibility now varies state by state. Currently, a NY family
earning $18,000 a year qualifies for Medicaid, but Louisiana only provides coverage for that family’s children. In 2014, however, most states will cover families of four with an income of $30,000 with the federal government picking up almost all the costs. The expectation is that nearly 15 million more Americans will have access to primary care doctors. To ensure we have enough doctors to see these Medicaid patients, Medicaid will provide a pay bump starting in 2013.

Also in 2014, individuals without insurance and small businesses may pool together to get group rates through health insurance exchanges, an “Amazon.com” for health insurance with standardized plans that provide benefits as good as the ones Congress gets – literally in this case, as Congress members must purchase health insurance from these exchanges. To make these plans affordable, individuals and families who make up to four times the poverty level may buy these plans at heavily subsidized rates, paying no more than 8 to 9 percent of their incomes for the premiums. Small businesses with fewer than 50 employees will get tax credits of up to 50 percent of the premium’s value.

**What about those on Medicare?**

Simply put – better Medicare. Over the next 10 years, ACA will eliminate the coverage gap or “doughnut hole” in the Medicare Part D prescription drug plan. Already this year, those who fall into the doughnut hole will receive rebates of up to 50 percent of their out-of-pocket drug costs. Medicare beneficiaries also receive preventive care with no co-pays including a free annual wellness visit.

**How does the taxpayer benefit?**

Currently, we all pay for the skyrocketing cost of health care through the growth in Medicare and Medicaid, and the supplemental “charity care” funds for hospitals and providers who treat the uninsured. ACA turns these public programs into innovators in reducing costs while maintaining or improving quality with the hope that the private insurance industry will quickly adopt what works well.

Medicare cost controls won’t take the form of rationing necessary care. Instead, we’ll move away from our fragmented and inefficient fee-for-service system. Physicians and hospitals will have the incentive to deliver high quality coordinated care through investments in electronic health records, comparative effectiveness research, and new payment models that pay for quality, not just quantity. Medicare will reduce the billions spent on things that don’t lead to better care for people who really need it – extra subsidies for HMOs in the Medicare Advantage plans that deliver mediocre results, outrageous prices for prescription drugs, preventable hospital readmissions and complications from infections picked up in the hospital. The ACA also makes the largest investment we’ve ever seen in fighting waste, fraud, and abuse in the system.

These reforms are just the beginning, but I have no doubt: These first steps will make a huge difference to the 35 million Americans who don’t have coverage today while also making health care more secure and reliable for the 255 million who do.

*This article was written for the September 2012 issue of The CSA News by Tim Foley, political director, Committee of Interns and Residents/SEIU.*