PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT: HOW THEY WILL HELP MILLIONS OF UNINSURED AND UNDERINSURED AMERICANS GAIN AFFORDABLE, COMPREHENSIVE HEALTH INSURANCE

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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the premium tax credits that will be available to families under the Patient Protection and Affordable Care Act beginning in 2014. Recent trends in the numbers of people in the United States who are uninsured or underinsured demonstrate how critical premium tax credits and the law's related insurance affordability programs and reforms will be to ensure both the health and financial security of working families. In September, the Census Bureau reported that the number of people without health insurance climbed to 49.9 million people in 2010, over 13 million more than were uninsured a decade ago. Among people who do have health insurance, The Commonwealth Fund estimates that in 2010, 29 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003.

Both these trends have resulted in serious financial and health consequences for working families. An estimated 75 million adults under age 65, both with and without health insurance, reported a time in 2010 when they did not get needed health care because of the cost, up from 47 million in 2001. And 73 million adults said that they had had difficulty paying medical bills or were paying off medical debt, up from 58 million in 2005. With its array of affordable health insurance programs and new consumer protections set to launch in 2014, the Affordable Care Act will substantially reverse these trends, ensuring that all Americans will have access to affordable and comprehensive health insurance coverage.

The Health Insurance Coverage of U.S. Families in 2010: Increases in Uninsured and Underinsured

- Nearly 50 million people in the U.S. were without health insurance in 2010, an increase of 13 million people over the last decade.

- Families with incomes under $50,000 are the most at risk for not having health insurance. Twenty-seven percent of people with incomes under $25,000 were without health insurance in 2010, with nearly a million more people in this income range losing coverage in 2010.

- Massachusetts, which implemented a reform law similar to the Affordable Care Act in 2006, leads the nation in coverage rates, with just 5.7 percent of its under-65 population lacking

health insurance. Texas has the highest rate of uninsured people: 27.7 percent of its nonelderly population is uninsured.

- The Affordable Care Act's new provision that allows children up to age 26 to stay on or join their parents' insurance policies reduced the percentage of uninsured young adults ages 19 to 25 to 29.7 percent in 2010, down from 32.7 percent in 2009. This is the largest one-year decline in the uninsured rate for young adults in the last decade, and it translates into 787,000 more young adults with coverage.

- The nation's high unemployment rate continues to take a toll on families' health insurance. The percentage of people with coverage through an employer declined to 55.3 percent in 2010, with 1.5 million fewer people enrolled in employer plans than in 2009.

- More than half (57%) of working-age adults who lost a job with health benefits became uninsured over the 2008–2010 period.

- In 2011, the average family premium for employer plans has climbed to $5,429 per year for single coverage and $15,073 for a family coverage, placing COBRA coverage out of reach for low- and moderate-income people when they lose their jobs. Just 14 percent of Americans who lost a job with benefits in the last two years enrolled in COBRA.

- Similarly, the individual insurance market is often unaffordable because of underwriting on health status and high premiums. In 2010, 60 percent of adults under age 65 who shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford, and 35 percent were turned down by an insurance carrier or had a specific health problem excluded from coverage.

- 72 percent of working-age adults who lost a job with benefits and became uninsured between 2008 and 2010 delayed needed health care because of the cost. The same percentage reported they had problems paying medical bills or were paying off medical debt over time.

- A combination of rapid growth in the cost of health insurance, greater exposure to health care costs, and declining incomes means that growing numbers of families are spending more of their earnings on health care. Nearly one-third (32%) of working-age adults, or an estimated 49 million people, spent 10 percent or more of their income on out-of-pocket costs and premiums in 2010, up from 21 percent, or 31 million people, in 2001.

- Twenty-nine million working age adults who had health insurance in 2010 had such high out-of-pocket costs relative to their incomes that they were effectively underinsured; this is an increase from 16 million in 2003. People with low and moderate incomes were underinsured at the highest rates: 26 percent of working-age adults with incomes below 200 percent of the federal poverty level were underinsured in 2010.

The Affordable Care Act Will Substantially Reduce the Number of Americans Who Are Uninsured or Underinsured

- Current trends in uninsured and underinsured rates will be significantly reversed under the provisions in the Affordable Care Act.

- The law's most significant coverage provisions will begin in 2014, with a substantial expansion in Medicaid eligibility that will cover adults earning up to 133 percent of the poverty level, or $29,726 for a family of four, as well as subsidized private coverage, available through new state insurance exchanges, for families earning up to 400 percent of poverty, or $89,400 for a family of four.

- The state insurance exchanges are the centerpiece of the law's coverage provisions, providing options for individuals and small businesses. The exchanges will create a new marketplace that will serve as the central portal through which people can get coverage if they do not have an affordable employer-based health plan. People will fill out one application for all insurance affordability programs: Medicaid, the Children's Health Insurance Program, the Basic Health Program (at state option), or premium tax credits for private plans known as qualified health plans (QHPs) sold in the exchanges. Consumers will have an array of health plan choices, with clear information on what their health plans cover and what their cost-sharing responsibilities are.

- Governors of 11 states have signed legislation since the passage of the Affordable Care Act to establish insurance exchanges. Governors in four states have signed legislation that signals an intent to establish an exchange or to study the establishment of an exchange. Governors in eight states have pursued or are considering alternatives to establishing exchanges through nonlegislative means.

- Starting in 2014, people with household incomes between 100 percent and 400 percent of poverty ($22,350–$89,400 for a family of four) who lack access to affordable insurance will be eligible for a tax credit to offset the cost of premiums for private health plans purchased in the exchanges.

- Taxpayers eligible for tax credits are required to make contributions to their premiums as a share of their income, from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private qualified health plans sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, for people with low incomes, the average costs covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150%–199% of poverty),

and 73 percent (200%–249% of poverty). In addition, qualified health plans will have limits on out-of-pocket spending related to income.

- As an example, a family of four with an income of $35,000 who is eligible for a tax credit would make a premium contribution of 4 percent of their income, or $1,405. If the policyholder is age 40, this family's premium for a benchmark plan in a medium-cost area of the country would be about $12,130 in 2014. Their tax credit would thus be equal to the benchmark premium minus their required contribution, or $10,725.

- About 90 percent of legal residents who are currently uninsured would gain premium tax credits or Medicaid. Of the 49 million people under age 65 who are uninsured, 43 percent have incomes under 133 percent of the poverty level and would be eligible for Medicaid. A quarter have incomes between 133 and 249 percent of poverty and would be eligible for premium tax credits that would cap their premium contribution at between 3 percent and 8.05 percent of their income, as well as reduced cost-sharing. Thirteen percent have incomes between 250 percent and 399 percent of poverty and would be eligible for tax credits that would cap their premium contributions at from 8.05 percent to 9.5 percent of income. Ten percent of those currently uninsured have incomes of 400 percent of poverty or more and would not be eligible for tax credits; however they would be eligible to buy coverage through the exchanges or in the individual market that features new consumer protections against underwriting, includes the essential benefit package, and limits cost-sharing. About 10 percent of those currently uninsured are undocumented immigrants who would not be eligible to purchase coverage through the exchanges.

- The Congressional Budget Office (CBO) estimates that under the law, 34 million adults and children will become newly covered by 2020. An estimated 16 million uninsured people will gain coverage through Medicaid, and 18 million will gain coverage through the state insurance exchanges or employer plans. Those newly covered in the exchanges are estimated to be joined by 8 million people shifting from the individual market and employer plans—in large part because of more affordable premiums and lower out-of-pocket costs. Of those purchasing health plans through the exchanges, CBO estimates that about 20 million people will be eligible for premium tax credits, with an average credit of $6,740.

- The Affordable Care Act's new consumer protections, income-based cost-sharing tax credits, and limits on out-of-pocket costs, and a new essential health benefit package are estimated to reduce the number of people who are underinsured by 70 percent. If the reforms were implemented today, there would be 20 million fewer underinsured adults in the U.S.

The Affordable Care Act Will Reduce the Federal Deficit over 2012–2021 and Lower Premiums

- The CBO estimates the Affordable Care Act will reduce the federal deficit by $124 billion over the period 2012–2021. The net cost of the Medicaid expansion, premium and cost-sharing tax

credits, and small-business tax credits ($1,151 billion) over 2012–2021 will be more than offset by savings from new revenues and from health care delivery system reforms aimed at improving the quality and cost of care.

- Cutler, Davis, and Stremikis estimate greater savings than CBO does from the law's health care delivery system reforms. They project $406 billion in savings by 2019, and consequently a much greater net decrease in the deficit: $400 billon.

- If the combination of insurance and delivery system reforms are effective in slowing the growth in premiums by just 1 percent below annual projected rates of increase, based on historical trends, the cost of family health insurance will drop by an average of $995 annually by 2015 and by $2,323 by 2020.

- Health care cost growth has begun to moderate. In 2009, as health reform was being debated, total national health expenditures were projected to reach $4.9 trillion in 2020. This baseline was used by federal scorekeepers evaluating the law and estimating the cost of providing coverage for the uninsured and premium subsidies for working families. Expenditures are now projected to reach $4.6 trillion in 2020, 5.6 percent below original estimates.

- By using the higher 2009 health system spending baseline, analysts assumed that covering the uninsured and providing premium subsidies would be more expensive for the federal government than now appears to be the case. The offsetting revenue estimates, by contrast, are less sensitive to the slowdown in health expenditures—legislative provisions such as taxes on wealthy individuals, lower Medicare Advantage payments, and productivity adjustments for hospitals can still be expected to produce significant federal budget savings. If scorekeepers were to redo the original estimates based on these new projections, the deficit reduction generated by health reform would be greater.

- The slowdown in health care costs in the last two years has saved substantially more in national health expenditures ($274 billion less by 2020 than originally estimated) than the amount the Centers for Medicare and Medicaid Services (CMS) had estimated health reform will have increased expenditures in 2020 ($74 billion).

- The slowdown also benefits employers, households, and state governments. In 2009, CMS estimated that total health expenditures would consume 21 percent of the GDP in 2020. Now, with health reform, it estimates that health spending will be 19.8 percent of GDP. And instead of increasing at an annual rate of 6.8 percent between 2015 and 2020, as projected prior to reform, health spending with health reform in place is now projected to grow 6.3 percent annually.

Conclusion

The early provisions of the Affordable Care Act that went into effect one year ago are already having an effect on Americans' health insurance coverage, with 787,000 more young adults covered in 2010 compared with 2009. But the erosion in employer coverage resulting from job losses, coupled with fewer companies offering health insurance, underscores the need for federal and state policymakers to continue implementing the Affordable Care Act. After 2014, when the law is fully implemented, U.S. families will have new affordable and comprehensive health insurance options through the substantial expansion of Medicaid and new premium tax credits, and cost-sharing limits that will substantially improve the affordability of both coverage and care. New consumer protections against basing coverage and premiums on a family's health, plus a new standard for benefits, will enhance the ability of people to shop for coverage on their own and make an informed health plan choice. In addition, while much of the recent national debate has focused on lowering the costs of Medicare and reducing the federal deficit, the same forces that are driving up public program costs are also increasing costs for working families. With its extensive set of delivery and insurance market reforms, the Affordable Care Act focuses on improving quality and affordability throughout the entire health care system. In combination, these reforms will significantly reduce the number of people in each state who either lack health insurance or have such high out-of-pocket costs that they are underinsured. For the 50 million adults and children who were without coverage in 2010 and the additional 29 million adults who were insured but not protected from high out-of-pocket costs, the 2014 reforms cannot come soon enough.

Thank you.

PREMIUM TAX CREDITS UNDER THE AFFORDABLE CARE ACT: HOW THEY WILL HELP MILLIONS OF UNINSURED AMERICANS GAIN AFFORDABLE, COMPREHENSIVE HEALTH INSURANCE

Thank you, Mr. Chairman, for this invitation to testify on the premium tax credits that will be available to families under the Patient Protection and Affordable Care Act starting in 2014. Recent trends in the numbers of people in the United States who are either uninsured or underinsured demonstrate how critical premium tax credits and the law's related insurance affordability programs and reforms will be to ensure both the health and financial security of working families. In September, the Census Bureau reported that the number of people without health insurance climbed to 49.9 million people in 2010, more than 13 million more than were uninsured a decade ago. Among people who do have health insurance, The Commonwealth Fund estimates that in 2010, 29 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003.

Both these trends have had serious financial and health consequences for working families. An estimated 75 million adults under age 65, both with and without health insurance, reported a time in 2010 when they did not get needed health care because of the cost, up from 47 million in 2001. And 73 million adults said that they had had difficulty paying medical bills or were paying off medical debt, up from 58 million in 2005. With its array of affordable health insurance options and new consumer protections set to launch in 2014, the Affordable Care Act will substantially reverse these trends, ensuring that all Americans will have access to affordable and comprehensive health insurance coverage.

Health Insurance Coverage of U.S. Families in 2010: Increases in Uninsured and Underinsured People

New data from the Census Bureau in September show that nearly 50 million people in the U.S. were without health insurance for all of 2010. This continues a steady increase in the number of people who are uninsured over the last decade. Over 13 million more people were without health insurance in 2010 than in 2000 (Exhibit 1).[1]

Families with incomes under $50,000 continue to be the most at risk for not having health insurance. Twenty-seven percent of people with incomes under $25,000 were without health coverage in 2010, with nearly a million more people in this income range losing coverage in 2010 (Exhibit 2) Nearly 22 percent of those in families with incomes between $25,000 and $50,000 were uninsured.

Massachusetts leads the nation in the rate of coverage, with just 5.7 percent of its under-65 population and 6.6 percent of its 19-to-64-year-old population lacking health insurance (Exhibit 3). This stands in stark contrast to Texas, where 27.7 percent of the nonelderly population and 32.8 percent of

[1] United States Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, Sept. 2011.

the 19-to-64-year-old population is uninsured, the highest rates in the U.S. In 2006, Massachusetts implemented a universal health insurance system much like the one advanced by the Affordable Care Act, and the state has since experienced a steady improvement in insurance coverage across its population.

High Unemployment Continues to Take a Toll on Coverage

Employer-based health plans continues to be the primary source of coverage for the majority of people in the United States. But rising health care costs have helped erode coverage, particularly for small-business employees, over the last decade. In addition, continuing high rates of unemployment in have left increasing numbers of people without job-based health insurance. The percentage of people with insurance coverage through an employer declined to 55.3 percent in 2010, with 1.5 million fewer people enrolled in employer plans than in 2009 (Exhibit 4). The Census Bureau reports that 48.4 million people ages 18 to 64 did not work at least one week in 2010, up from 45.4 million in 2009. Among people in that age group who were not working, nearly 30 percent were uninsured, two times the rate of people who were employed full-time.

A recent Commonwealth Fund report found that more than half (57%) of working-age adults who lost a job with health benefits became uninsured over the period 2008 to 2010 (Exhibit 5).[2] Families with low and moderate incomes have been particularly hard hit. Adults with incomes under 200 percent of the federal poverty level, about $44,700 for a family of four, were less likely to have benefits through a job that was lost, but those who did have benefits through their former job were much more likely to become uninsured than adults with higher incomes.

While employees of companies with more than 20 workers who lose a job can stay on their employer's policy for up to 18 months under COBRA (Consolidated Omnibus Budget Reconciliation Act), they must pay the full premium. Average family premiums in employer plans climbed to $5,429 per year for single coverage and $15,073 for a family plan in 2011, placing coverage out of reach for workers who have also lost a significant amount of their income (Exhibit 6).[3] Just 14 percent of people who lost a job with benefits in the last two years enrolled in the COBRA program. Those with low incomes were least likely to enroll in COBRA: only 8 percent continued their coverage through COBRA, compared to 21 percent of those with higher incomes.

Other than COBRA, there are few options for workers who lose their jobs and their health benefits. In most states, insurance coverage through public insurance programs like Medicaid and the Children's Health Insurance Program is available only to pregnant women, children, and parents with very low incomes; less than half of states cover childless adults. People who buy insurance in the individual insurance market must pay the full premium, and, in most states, policies are underwritten on

[2] M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, Aug. 2011).

[3] Kaiser Family Foundation/Health Research and Educational Trust, 2011 Employer Health Benefits Survey, September 2011, http://ehbs.kff.org.

the basis of health—meaning that a health plan can charge people a higher premium, exclude a health condition from coverage, or turn down someone for coverage altogether because of a preexisting condition. The Commonwealth Fund found that in 2010, 60 percent of adults under age 65 who shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford, and 35 percent were turned down by an insurance carrier or had a specific health problem excluded from coverage (Exhibit 7).[4]

Unemployed adults who become uninsured suffer significant health and financial consequences. In the Commonwealth Fund report, 72 percent of working-age adults who lost a job with benefits and became uninsured said that they had either not gone to a doctor when they were sick, had not filled a prescription, did not get a recommended test or follow-up visit, or did not get recommended specialist care (Exhibit 8).[5] And 72 percent reported problems with medical bills, including not being able to pay, being contacted by a collection agency about unpaid bills, having to change their way of life to pay bills, or having to pay off bills over time (Exhibit 9).

Young Adults Gain Coverage in 2010

While young adults have among the highest unemployment rates of any age group, the Affordable Care Act's new provision that allows children up to age 26 to stay on or join their parents' insurance policy has reversed a decade-long increase in the number of young adults without health insurance since it went into effect in September 2010.[6] The percentage of uninsured young adults ages 19 to 25 without health insurance declined by 3 percentage points in the last year, dropping to 29.7 percent in 2010, down from 32.7 percent in 2009.[7] This is the largest one-year decline in the uninsured rate for young adults in the last decade, and it translates into 787,000 more young adults with insurance coverage in 2010 compared with 2009, with most of the increase coming from employer-based coverage. Young adults made gains across the country: in California, 131,000 young adults gained health insurance; in Texas, 83,000 young adults gained coverage.

Health Care Cost Growth and the Growing Numbers of Underinsured Adults

A combination of rapid growth in the cost of health insurance, greater exposure to health care costs, and declining incomes means that growing numbers of families are spending more of their earnings on health care. A 2010 report by The Commonwealth Fund found that premiums in employer

[4] S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010, The Commonwealth Fund, March 2011.

[5] M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help, The Commonwealth Fund, August 2011.

[6] S. R. Collins, T. Garber, and R. Robertson, Realizing Health Reform's Potential: How the Affordable Care Act Is Helping Young Adults Stay Covered, The Commonwealth Fund, May 2011.

[7] Analysis of the March 2011 Current Population Survey by Nick Tilipman and Bhaven Sampat of Columbia University for the Commonwealth Fund.

health plans climbed by 41 percent between 2003 and 2009, while deductibles in those plans jumped by 77 percent.[8] Yet over the last decade, real family incomes have hardly budged, barely regaining their levels prior to the recession of 2000–2001, before falling again during the 2008 economic downturn.[9]

In a March 2011 report, The Commonwealth Fund found that in 2010, nearly one-third (32%) of working-age adults, or an estimated 49 million people, spent 10 percent or more of their income on out-of-pocket health care costs and insurance premiums (Exhibit 10).[10] This is an increase of more than 10 percentage points since 2001, when about 21 percent of families, or 31 million people, spent that much of their income on health care.

The burden of health care costs has spread most dramatically among Americans with the lowest incomes. In 2010, fully half of adults in families with incomes less than 100 percent of the federal poverty level ($22,050 for a family of four) spent 10 percent or more of their income on health care costs and premiums, more than double the share who spent that amount in 2001.

Health care costs as a share of household budgets grew among adults who were insured all year as well as among those who were uninsured for a time during the year. In 2010, 35 percent of adults who had been uninsured for at least part of the year spent more than 10 percent of their income on health care costs, up from 27 percent in 2001. Among adults who were insured all year, 31 percent spent 10 percent or more of their income on out-of-pocket costs and premiums, up from 19 percent in 2001.

Increasing numbers of adults are in health plans with high health insurance deductibles. The proportion of insured adults with deductibles of $1,000 or more nearly doubled over the past five years, increasing from 10 percent in 2005 to 18 percent in 2010 (Exhibit 8). People with private insurance and higher incomes were slightly more likely to have a health plan with a high deductible than were those with lower incomes.

Cathy Schoen and colleagues at The Commonwealth Fund found that 29 million working-age adults who had health insurance in 2010 had such high out-of-pocket costs relative to their incomes that they were effectively underinsured (Exhibit 11).[11] This is an increase from 16 million underinsured adults in 2003. People with low and moderate incomes are underinsured at the highest rates: 26 percent of

[8] C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits* (New York: The Commonwealth Fund, December 2010).

[9] Council of Economic Advisors, Economic Report of the President, February 2011, Table B-33, http://www.gpoaccess.gov/eop/tables11.html.

[10] S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010, The Commonwealth Fund, March 2011.

[11] C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9): 1762–71.

working-age adults with incomes under 200 percent of the poverty level ($21,780 for an individual and $44,700 for a family of four) were underinsured in 2010.

How the Affordable Care Act Will Bring Additional Relief to Working Families

These long-term upward trends in both the uninsured and underinsured rates in the U.S. will be significantly reversed by provisions in the Affordable Care Act, among the most important of which focus on softening the growing health care cost burden for low- and moderate-income families. A large number of provisions went into effect last year and are continuing to be rolled out this year (Exhibit 12). They include young adults being able to stay on or join their parents' policies, no preexisting condition exclusions for children under 19, a ban on lifetime benefit limits, coverage of preventive services with no cost-sharing, and preexisting condition insurance plans that are enrolling people with chronic health problems in all 50 states.[12] But the biggest changes brought about by the law will begin in 2014, when Medicaid eligibility will be substantially expanded for adults earning up to 133 percent of poverty, or $29,726 for a family of four, and subsidized private coverage will be available through new state insurance exchanges for families earning up to 400 percent of poverty, or $89,400 for a family of four.

State Insurance Exchanges

The state insurance exchanges are the centerpiece of the Affordable Care Act's coverage changes, providing insurance options for individuals and small businesses. The exchanges will create a new marketplace that will serve as the central portal through which people will go to for coverage if they do not have an affordable employer-based health plan. The individual and small-group markets will continue to function outside of the exchanges, but new insurance market regulations against underwriting on the basis of health will apply to plans sold inside and outside the exchanges. People will come to the exchanges, either in person or online, fill out one application, and receive a determination of eligibility, depending on their income, for the law's insurance affordability programs: Medicaid, the Children's Health Insurance Program, the Basic Health Program (at state option), or premium tax credits for private " qualified health plans" (QHPs) sold in the exchanges.[13] Consumers will have an array of health plan choices with clear information about what their health plans cover and wheat their cost-sharing responsibilities are. This is a significant departure from the individual market of today, where consumers often have scant information about the health plans they must choose among.

In order to establish an exchange, states must give themselves the legal authority to do so. State legislatures are accomplishing this by passing legislation for their governors to sign, or governors are pursuing other mechanisms to establish and operate exchanges, such as an executive order. As of October, governors of 11 states have signed legislation since passage of the Affordable Care Act to

[12] J. P. Hall and J. Moore, Realizing Health Reform's Potential: Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable, The Commonwealth Fund, June 2011.

[13] S .R. Collins, "HHS's Proposed Regulation for Health Insurance Exchanges: An Emphasis on State Flexibility, Part I," *The Commonwealth Fund Blog,* July 2011.

establish insurance exchanges in their states (Exhibit 13).[14] Governors in four states have signed legislation that signals an intent to establish an exchange or to study the establishment of an exchange. Governors in eight states have pursued or are considering alternatives to establishing exchanges through nonlegislative means.

The federal government is providing considerable assistance to states to establish their exchanges. Nearly all states received $1 million grants last year to get started. So far this year, 16 states and the District of Columbia have been awarded multimillion-dollar establishment grants over the last few months.

States that decline to establish an exchange, or that have not made sufficient progress toward creating an exchange by January 2013, will work with the U.S. Department of Health and Human Services (HHS) to set up a federally facilitated exchange in their state. But new proposed regulations from HHS would allow for the conditional approval of an exchange if states are at an advanced stage in the development of their exchanges but cannot demonstrate complete readiness by January 2013.[15] In addition, states that do not have exchanges ready for operation in 2014 may apply to operate the exchange in 2015 or in subsequent years.

Premium Tax Credits

Starting in 2014, people with household incomes between 100 percent and 400 percent of the poverty level ($22,350 to $89,400 for a family of four) who lack access to affordable insurance will be eligible for a tax credit to offset the cost of premiums for private health plans purchased through the insurance exchanges. To be eligible for the tax credits, someone may not be eligible for "minimum essential coverage" through an employer or other insurance program and must be enrolled in a qualified health plan offered through the exchange. Minimum essential coverage is health insurance that is considered affordable and provides a minimum level of cost protection.

In general, people with incomes under 133 percent of poverty will be eligible for Medicaid, but legal immigrants in the five-year waiting period for Medicaid are eligible for tax credits (Exhibit 14). Under the law, taxpayers eligible for tax credits are required to make contributions to their premiums, as a share of their income, of from 2 percent to 9.5 percent. Those eligible for tax credits will have a choice of private QHPs sold through the exchanges that will offer a comprehensive set of benefits known as the essential benefit package. Insurers will offer these plans at four levels of cost-sharing: bronze plans (covering on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs). However, for people with low incomes, the average costs covered by the silver plan will be increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150%–199% of poverty), and 73 percent (200%–249% of poverty). In addition,

[14] S. R. Collins, T. Garber, "State Health Insurance Exchange Legislation: A Progress Report," *The Commonwealth Fund Blog,* Sept. 2011, http://bit.ly/oymbl4 .

[15] S. R. Collins, "HHS's Proposed Regulation for Health Insurance Exchanges: An Emphasis on State Flexibility, Part I," *The Commonwealth Fund Blog,* July 19, 2011. http://bit.ly/qUQ5bS .

QHPs will have limits on out-of-pocket spending related to income that range from $1,983 for a single policy and $3,967 for a family policy for those earning up to 199 percent of poverty ($44,700 for a family of four) to $3,967 for a single policy and $5,950 for a family policy for those earning up to 400 percent of poverty ($89,400 for a family of four). For those earning 400 percent of poverty or more, out-of-pocket limits are set at the level for health saving accounts or $5,950 for a single policy and $11,900 for a family policy.

If these coverage options were available this year, of the 49 million people under age 65 who are uninsured, the 43 percent of those with incomes under 133 percent of poverty would be eligible for Medicaid (Exhibit 15).[16] The quarter (24%) with incomes between 133 percent and 249 percent of poverty would be eligible for premium tax credits that would cap their premium contribution at 3 percent to 8.05 percent of their income, as well as for reduced cost-sharing. The 13 percent with incomes between 250 percent and 399 percent of poverty would be eligible for tax credits that would cap their premium contributions at 8.05 percent to 9.5 percent of their income. The 10 percent who are currently uninsured and have incomes of 400 percent of poverty of more and would not be eligible for tax credits; however, they would be eligible to buy coverage through exchanges or the individual market, with new consumer protections against underwriting, the essential benefit package, and limits on cost-sharing. About 10 percent of those currently uninsured are undocumented immigrants and would not be eligible to purchase coverage through the exchanges.

What Will Be the Amount of the Premium Tax Credit?

In its proposed rule released in August regarding the premium tax credits, the U.S. Treasury Department clarifies that the amount of the credit will be equal to the difference between someone's required premium contribution and the premium of the "benchmark" health plan—the second-lowest-cost "silver plan" offered through the exchange.[17] This means that someone may choose a plan that is not the benchmark plan, but the amount of the tax credit will be determined based on the premium for the benchmark plan, not the plan they enroll in, which could be less or more than the benchmark. In addition, the tax credit amount cannot exceed the amount of the full premium.

To illustrate, a family of four has an income of $35,000, putting them at 150 percent of the poverty level (Exhibit 16). This means that their required premium contribution would be 4 percent of their income, or $1,405. If the policy holder is age 40, the Kaiser Family Foundation estimates that this family's premium for a benchmark plan in a medium cost area of the country would be about $12,130. The family's tax credit would thus be equal to the benchmark premium minus their required contribution, or $10,725. A family with slightly older parents would be charged a higher premium in the

[16] Analysis of the March 2011 Current Population Survey by Nick Tilipman and Bhaven Sampat of Columbia University for the Commonwealth Fund; estimates of uninsured undocumented immigrants by Jonathan Gruber and B. Dylan Bannon of MIT using the Gruber Microsimulation Model for the Commonwealth Fund.

[17] S. R. Collins, Proposed Rule on Premium Tax Credits: Who's Eligible and How Much Will They Help?, The Commonwealth Fund Blog, August 2011.

exchange. But the tax credit would also be higher, since the premium contribution for the family is a fixed share of its income.

A single person with an income of $17,000 is also at 150 percent of the poverty level (Exhibit 17). Her required premium contribution is also 4 percent of her income, or $690. If she is 40, the Kaiser Family Foundation estimates that her premium for a benchmark plan in a medium-cost area of the country would be about $4,500. Her tax credit would thus be equal to the benchmark premium minus her required contribution, or $3,810.

Advance credit payments vs. actual tax credits. When someone becomes eligible for a tax credit, the Treasury Department will pay the credit in advance directly to the insurance company, based on his or her most recent tax return. This means that recipients do not have to wait to get the tax credit as part of next year's tax return. But Treasury will reconcile the advance credit payments against the actual tax credit based on the tax return in the year in which the credit is applicable. In other words, if their household income is different in the year in which the advance credits were paid to the insurer, taxpayers will either: a) receive a refund on their return, if their income is lower and they were entitled to a larger tax credit, or b) owe a tax liability, if their income is higher and they were actually entitled to a smaller credit. In the latter case, repayments are capped for people with incomes under 400 percent of poverty to no more than $600 for married couples ($300 for singles) under 200 percent of poverty to $2,500 for married taxpayers ($1,250 for single) with incomes between 300 percent and 399 percent of poverty.

Are Employees with Employer Health Benefits Eligible for the Tax Credits?

Those whose employers offer minimum essential coverage that meets affordability and benefit standards will be generally ineligible for the tax credits. Under the Treasury Department's proposed rule, workers and their dependents who have an opportunity to enroll in their employers' health plans during an open enrollment period but fail to do so are not eligible. Conversely, someone who is laid off or leaves their job and becomes eligible for COBRA continuation coverage would be ineligible for premium tax credits only if he or she actually enrolled in COBRA.

Workers with unaffordable premiums or poor coverage. There will be one notable exception to the exclusion of those with access to employer coverage: when an employer plan does not meet the criteria for minimum essential coverage—that is, the plan offered would require employees to spend more than 9.5 percent of household income on premium contributions, or would provide less than a minimum level of cost protection (with minimum level defined as at least 60 percent of an individual's total medical costs on average for the year). In either case, a worker could become eligible for premium tax credits if her income was between 100 percent and 400 percent of poverty, unless she had already enrolled in the employer plan.

Under the law, if an employer has 50 or more workers and one of their employees becomes eligible for a tax credit, the employer would have to pay a fee to the Treasury. The fee would be the

lesser of $3,000 for each full-time worker who receives a premium tax credit or $2,000 for each full-time worker, excluding the first 30 workers.

Criteria for determining affordability of an employer plan. Treasury's proposed rule provides guidance to employers on how to determine whether an employee's premium contribution is affordable, but Treasury defers guidance on the minimum level of cost protection to a future regulation. Treasury notes that forthcoming guidance will provide flexibility to employers to meet the minimum standard. Regardless of whether an employee has a family plan or "self-only coverage," his employer coverage is considered unaffordable if the required contribution for self-only coverage exceeds 9.5 percent of household income. Someone may thus have a family plan for which he pays more than 9.5 percent of his household income, but if the contribution for self-only coverage is less than 9.5 percent of his income, he would be defined as having affordable coverage.

Employer "safe harbor" regarding penalties. In another simplification for employers, Treasury's proposed rule notes that in future guidance it will likely allow employers to determine whether coverage they offer to employees is affordable based on wages, rather than household income. This is because employers cannot easily determine their employees' household incomes. So for purposes of the fee, if a worker became eligible for a premium tax credit because his contribution for self-only coverage exceeds 9.5 percent of his household income, the employer would not be assessed a payment if the contribution is less than 9.5 percent of the employee's wages.

The Affordable Care Act Will Substantially Reduce the Number of Americans Who Are Uninsured or Underinsured

The Congressional Budget Office (CBO) estimates that 34 million adults and children will become newly covered by 2020 under the law (Exhibit 18).[18] An estimated 16 million uninsured people will gain coverage through Medicaid and 18 million will gain coverage through the state insurance exchanges or employer plans. Those newly covered in the exchanges are estimated to be joined by 8 million people shifting from the individual market and employer plans. Of those purchasing health plans through the exchanges, CBO estimates that about 20 million people will be eligible for premium tax credits, with an average credit of $6,740. With small firms expected to offer plans to about 5 million workers and their families through the exchanges, an estimated 30 million people may gain private insurance coverage through exchanges by 2020. More than 50 million people will be covered by Medicaid by 2020.

The effect of the Affordable Care Act on health insurance coverage in states across the country will be dramatic, with most states approaching the low uninsured rates that Massachusetts has achieved

[18] Congressional Budget Office, March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Washington, D.C.: CBO, 2011).

over the last five years (Exhibit 19). [19] In Texas, where 27 percent of the under 65 population is currently uninsured, fewer than 8 percent are estimated to be uninsured by 2019.

The Affordable Care Act's new consumer protections, income-based cost-sharing tax credits and limits on out-of-pocket costs, and new essential health benefit package will also dramatically reduce the numbers of people who are underinsured. The majority of people who are underinsured are in families with incomes under 250 percent of the poverty level. Families in this income group who become eligible for premium and cost-sharing tax credits will make the greatest gains both in the affordability of their insurance and its comprehensiveness. Schoen and colleagues estimate that the provisions of the law will reduce the number of underinsured Americans by 70 percent.[20] If the reforms were implemented today, that would mean that there would be 20 million fewer underinsured adults in the U.S.

The Affordable Care Act Will Reduce the Federal Deficit over 2012–2021 and Lower Premiums

The Congressional Budget Office estimates the Affordable Care Act will reduce the federal deficit by $124 billion between 2012 and 2021 (Exhibit 20).[21] The net cost of the Medicaid expansion, premium and cost-sharing tax credits, and small business tax credits ($1,151 billion) over 2012–2021 will be more than offset by savings from health care delivery system reforms and new revenues. The law includes an extensive set of new demonstration programs and incentives aimed at improving the quality and cost of health care. Such changes include innovations in payment, including higher reimbursement for preventive care services and patient-centered primary care, bundled payment for hospital, physician, and other services provided for a single episode of care, shared savings for accountable provider groups that assume responsibility for the continuum of a patient's care, and pay-for-performance incentives for Medicare providers.[22] Cutler, Davis, and Stremikis estimate greater savings than CBO does from the law's delivery system reforms. The authors estimate $406 billion in savings through delivery system reforms in the law by 2019, and consequently a much greater net decrease in the deficit: $400 billon by 2019.

Several additional provisions in the Affordable Care Act provisions may help lower the rate of premium growth over time. Requiring everyone to have health insurance will pool risks much more broadly than they are today by bringing in younger and healthier people. CBO estimates that this provision could lower premiums in the individual market and exchanges by 7 percent to 10 percent. CBO estimates that premiums would decline by an additional 7 percent to 10 percent because of lower administrative costs and greater economies of scale in the provision of insurance.[23]

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[19] The Commonwealth Fund Commission on a High Performance Health System, Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011, The Commonwealth Fund, October 2011.

[20] C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9): 1762–71.

[21] This estimate excludes the CLASS Act.

[22] D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending* (Center for American Progress and The Commonwealth Fund, May 2010).

[23] Congressional Budget Office, Letter to the Honorable Evan Bayh, Nov. 30, 2009.

The law also places controls on insurance premiums. Beginning in August 2012, health plans in the large-employer group market that spend less than 85 percent of their premiums on medical care and quality improvement activities, and plans in the small-employer group and individual markets that spend less than 80 percent on the same, will be required to offer rebates to enrollees.[24.] Carriers will pay rebates to enrollees in the form of a reduction in premiums or a rebate check. People with employer-based plans will receive rebates that are proportional to their premium contribution. Also beginning this year, any insurance carrier that increases its premiums by 10 percent or more in the individual or small-employer group insurance markets, effective on or after September 1, 2011, will have to justify the increase to states and the Department of Health and Human Services. [25] Starting in 2014, states can recommend that health plans be excluded from participation in the insurance exchanges if they have demonstrated a pattern of excessive or unjustified premium increases.

Cutler, Davis, and Stremikis estimate that if the combination of insurance and delivery system reforms are effective in slowing the growth in premiums by just 1 percent below annual projected rates of increase, based on historical trends, the cost of family health insurance would drop by an average of $995 annually by 2015 and by $2,323 by 2020.

Health care cost growth has begun to moderate.[26] In 2009, as health reform was being debated, total national health expenditures were projected to reach $4.9 trillion in 2020. This baseline was used by federal scorekeepers evaluating the law and estimating the cost of covering the uninsured and providing premium subsidies for working families. Today's figures show that expenditures are now projected to reach $4.6 trillion in 2020, 5.6 percent below original estimates.

By using the higher 2009 health system spending baseline, analysts assumed that providing coverage for the uninsured and premium subsidies would be more expensive for the federal government than now appears to be the case. The offsetting revenue estimates, by contrast, are less sensitive to the slowdown in health expenditures—legislative provisions such as taxes on wealthy individuals, lower Medicare Advantage payments, and productivity adjustments for hospitals can still be expected to produce significant federal budget savings. If scorekeepers were to redo the original estimates based on these new projections, the deficit reduction generated by health reform would be greater. More broadly, any reduction in health spending growth is reason for cautious optimism, as premium growth moderates and the public cost of providing affordable coverage to all is reduced. Indeed, the slowdown in health care costs in the last two years has already saved the nation substantially more in national health expenditures ($274 billion less by 2020 than originally estimated)

[24] S. R. Collins, "Medical Loss Ratio Regulations Good for Consumers," *The Commonwealth Fund Blog,* Nov. 2010.

[25] S. R. Collins, "New Review Process for "Unreasonable" Premium Hikes," *The Commonwealth Fund Blog,* Dec. 2010.

[26] K.Davis, Health Spending Continues to Moderate, Cost of Reform Overestimated, The Commonwealth Fund Blog, July 2011.

than the amount CMS had estimated health reform will have increased expenditures in 2020 ($74 billion).

The slowdown also benefits employers, households, and state governments. In 2009, CMS estimated that total health expenditures would consume 21 percent of the gross domestic product (GDP) in 2020. Now, with health reform, it estimates that health spending will be 19.8 percent of GDP. And instead of increasing at an annual rate of 6.8 percent between 2015 and 2020, as projected prior to reform, health spending with health reform is now projected to grow at 6.3 percent annually.

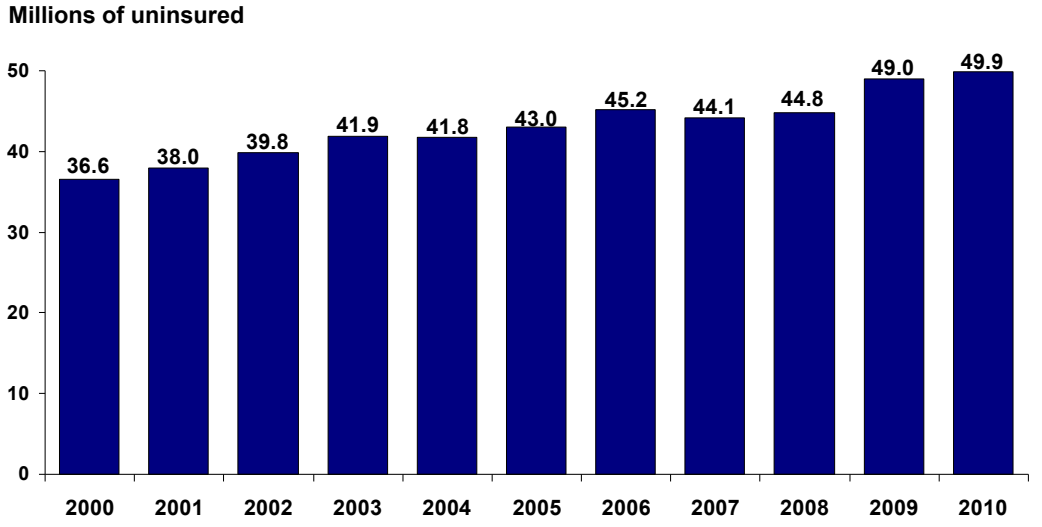
Conclusion

The early provisions of the Affordable Care Act that went into effect one year ago are already having an effect on American's health insurance coverage, with 787,000 more young adults covered in 2010 compared with 2009. But the erosion in employer coverage resulting from job losses, coupled with fewer companies offering health insurance, underscores the need for federal and state policymakers to continue implementing the Affordable Care Act. After 2014, when the law is fully implemented, U.S. families will have new affordable and comprehensive health insurance options through a substantial expansion in Medicaid and new premium tax credits and cost-sharing limits that will substantially improve the affordability of health insurance and health care. New consumer protections against basing coverage and premiums on a family's health and a new standard for benefits will enhance the ability of people to shop for coverage on their own and make informed health plan choices. In addition, while much of the recent national debate has focused on lowering the costs of Medicare and reducing the federal deficit, the same forces that are driving up public program costs are also increasing costs for working families. With its extensive set of delivery and insurance market reforms, the Affordable Care Act focuses on improving quality and affordability throughout the entire health care system.

In combination, these reforms will significantly reduce the number of people in each state who either lack health insurance or have such high out-of-pocket costs that they are underinsured. For the 50 million adults and children who were without coverage in 2010, and the additional 29 million adults who were insured but not protected from high out-of-pocket costs, the 2014 reforms cannot come soon enough.

Thank you.

Exhibit 1. Thirteen Million More People Uninsured Over Last Decade



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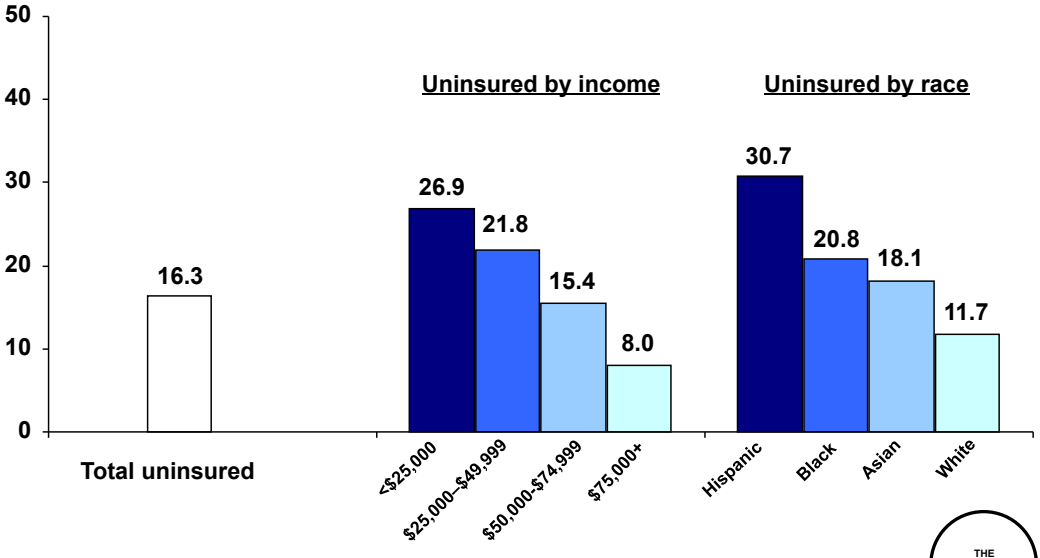
Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010* (Washington, D.C.: U.S. Census Bureau, Sept. 2011).

Exhibit 2. People with Low Incomes and Minorities Have Highest Uninsured Rates, 2010



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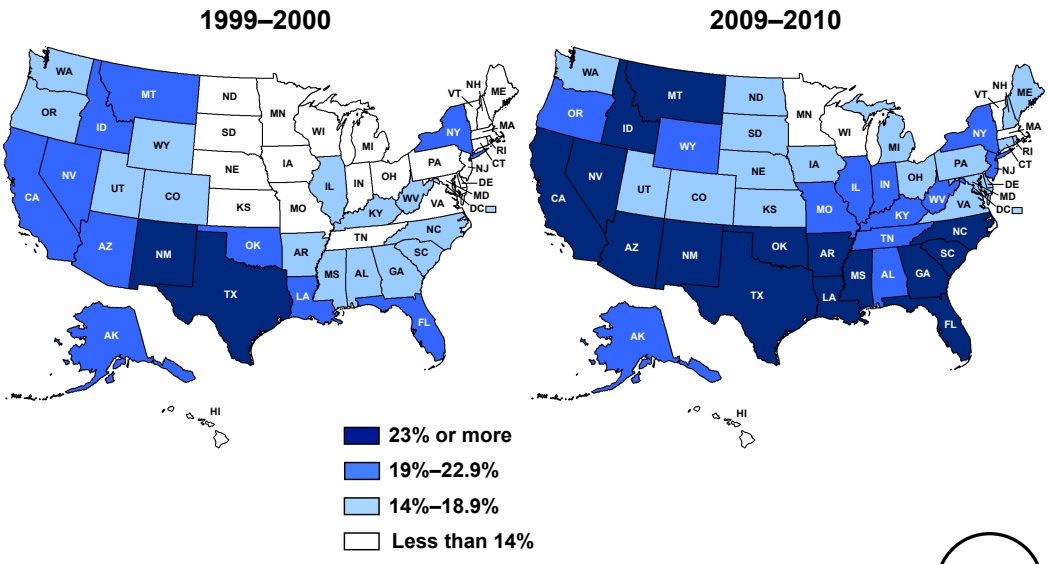
Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010* (Washington, D.C.: U.S. Census Bureau, Sept. 2011).

Exhibit 3. Percent of Adults Ages 19–64 Uninsured by State



Data: U.S. Census Bureau, 2000–01 (revised) and 2010–11 Current Population Survey, ASEC Supplement.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

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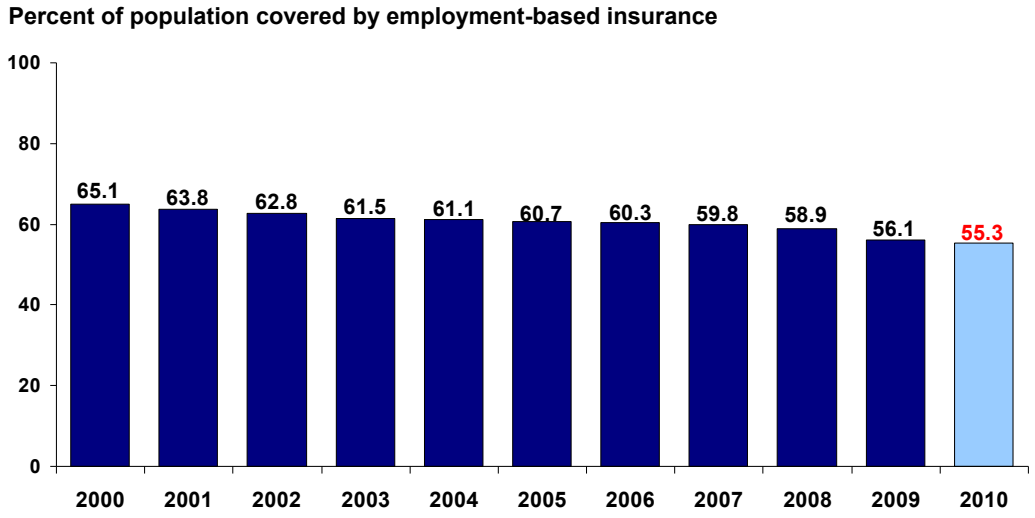
Exhibit 4. The Percent of People with Employment-Based Insurance Continued to Decline in 2010



Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2010* (Washington, D.C.: U.S. Census Bureau, Sept. 2011).

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Exhibit 5. Nearly Three of Five Adults Who Lost a Job with Health Benefits in the Past Two Years Became Uninsured

Percent of adults ages 19–64 who lost their job with employer-based benefits*

	Total^	<200% FPL	200% FPL or more	White	Black or Hispanic
Respondent lost job in past two years	18% 33 million	28% 20 million	11% 10 million	15% 18 million	25% 13 million
Respondent had insurance through job that was lost	46% 15 million	36% 7 million	69% 7 million	53% 10 million	41% 5 million
What happened when you lost your employer-based health insurance?					
Became uninsured	57	70	42	49	73
Went on spouse's insurance or found insurance through other source	25	22	29	27	21
Continued job-based coverage through COBRA	14	8	21	19	5

Note: FPL refers to federal poverty level.
* Job lost in the past two years.
^ Includes respondents who did not state their income level.
Source: M. M. Doty, S. R. Collins, R. Robertson, and T. Garber, *Realizing Health Reform's Potential—When Unemployed Means Uninsured: The Toll of Job Loss on Health Coverage, and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, Aug. 2011).

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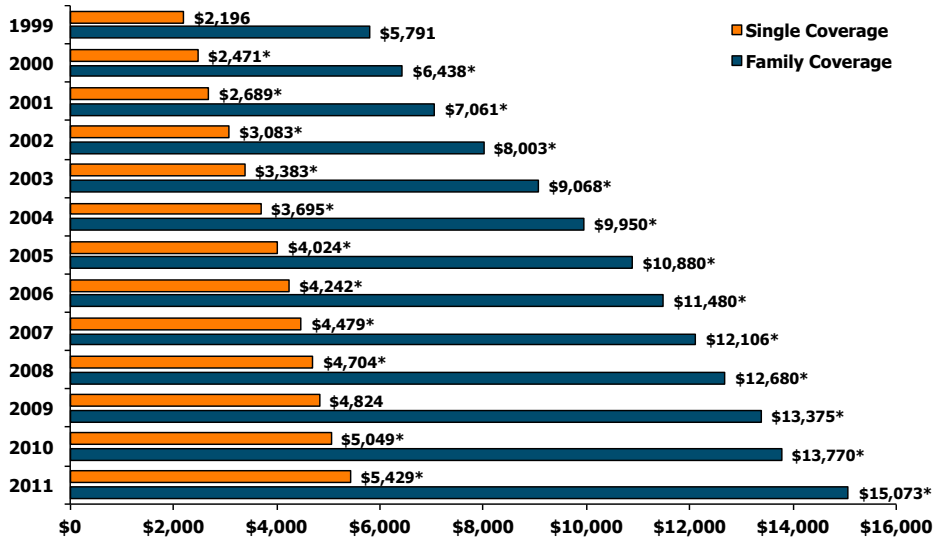
Exhibit 6. Average Annual Premiums for Single and Family Coverage, 1999–2011



* Estimate is statistically different from estimate for the previous year shown (p<.05).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2011.

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Exhibit 7. The Individual Insurance Market Is Not an Affordable Option for Many People

Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	Total 26 million	Health problem**	No health problem	<200% FPL	200%+ FPL
Found it very difficult or impossible to find coverage they needed	43% 11 million	53%	31%	49%	35%
Found it very difficult or impossible to find affordable coverage	60% 16 million	70	46	64	54
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	35% 9 million	46	20	38	34
Any of the above	71% 19 million	83	56	77	64

Note: FPL refers to federal poverty level. * Bought in the past three years. ** Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.
Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

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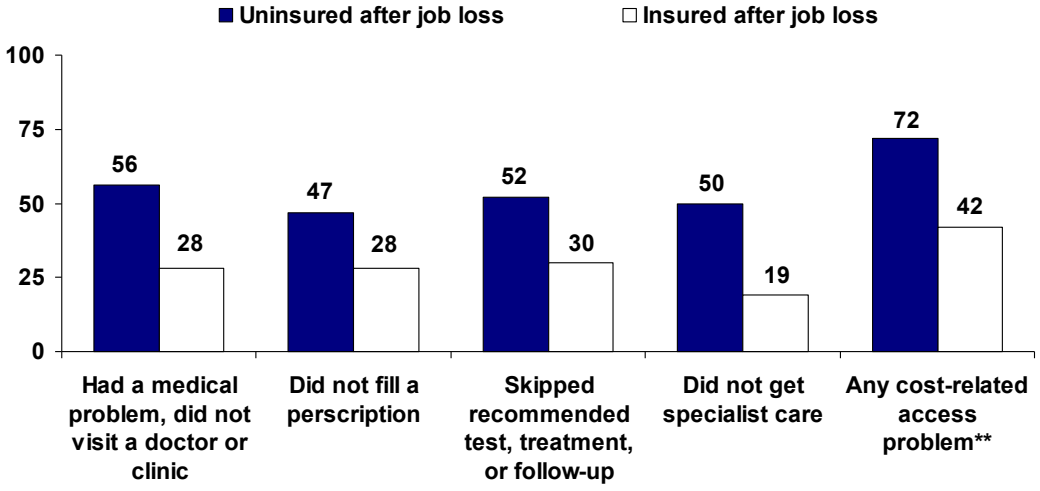
Exhibit 8. Three-Quarters of Adults Who Became Uninsured When They Were Laid Off Had Problems Getting the Care They Needed

Percent of adults ages 19–64 who lost a job with employer-based benefits*



* Job lost in the past two years.
** Includes any of the following because of cost: had a medical problem, did not visit a doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get specialist care.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

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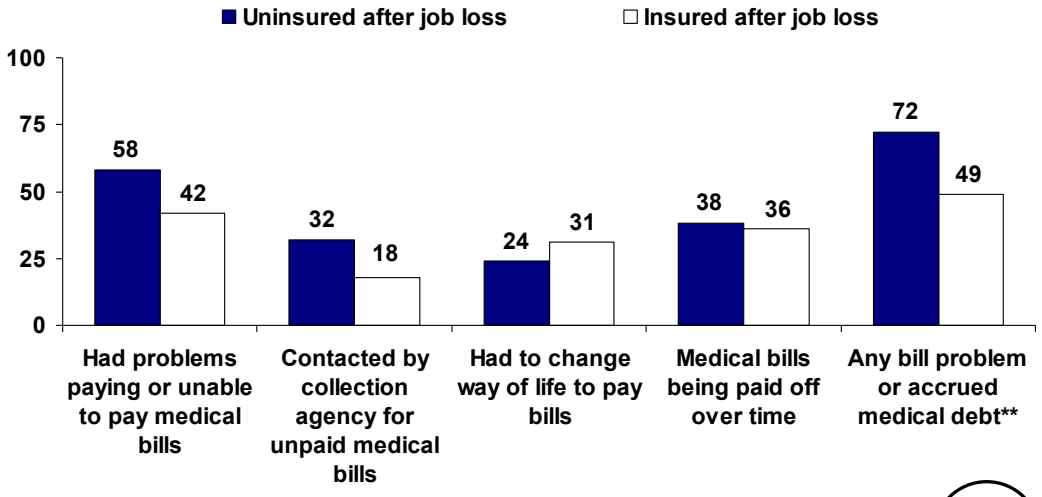
Exhibit 9. Adults Who Became Uninsured When They Were Laid Off Had Higher Rates of Medical Bill Problems and Debt Than Adults Who Remained Insured

Percent of adults ages 19–64 who lost a job with employer-based benefits*



* Job lost in the past two years.
** Had problems paying or unable to pay medical bills, contacted by collection agency for unpaid medical bills, had to change way of life to pay bills or had outstanding medical debt.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

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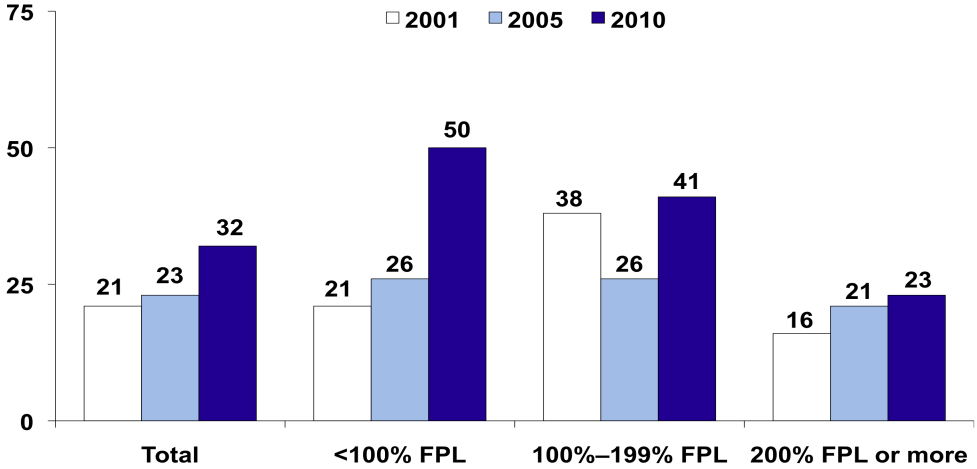
Exhibit 10. High Out-of-Pocket Spending Climbs Across Income Groups, 2001–2010

Percent of adults ages 19–64 who spent 10 percent or more of household income annually on out-of-pocket costs and premiums*



Note: FPL refers to federal poverty level.
* Base: Respondents who specified income level and private insurance premium/out-of-pocket costs for combined individual/family medical expenses.
Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

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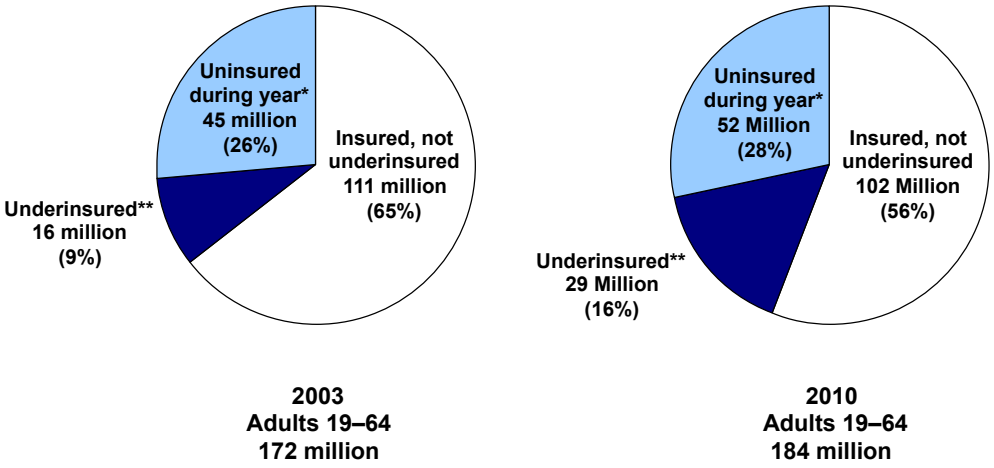
Exhibit 11. 2010: 29 Million Adults Under Age 65 Underinsured



* Uninsured during the year combines "insured now, time uninsured in the past year" and "uninsured now."
** Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
Source: C. Schoen, M. M. Doty, R. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2008 30(9):1762–71.
Data: 2003 and 2010 Commonwealth Fund Biennial Health Insurance Surveys.

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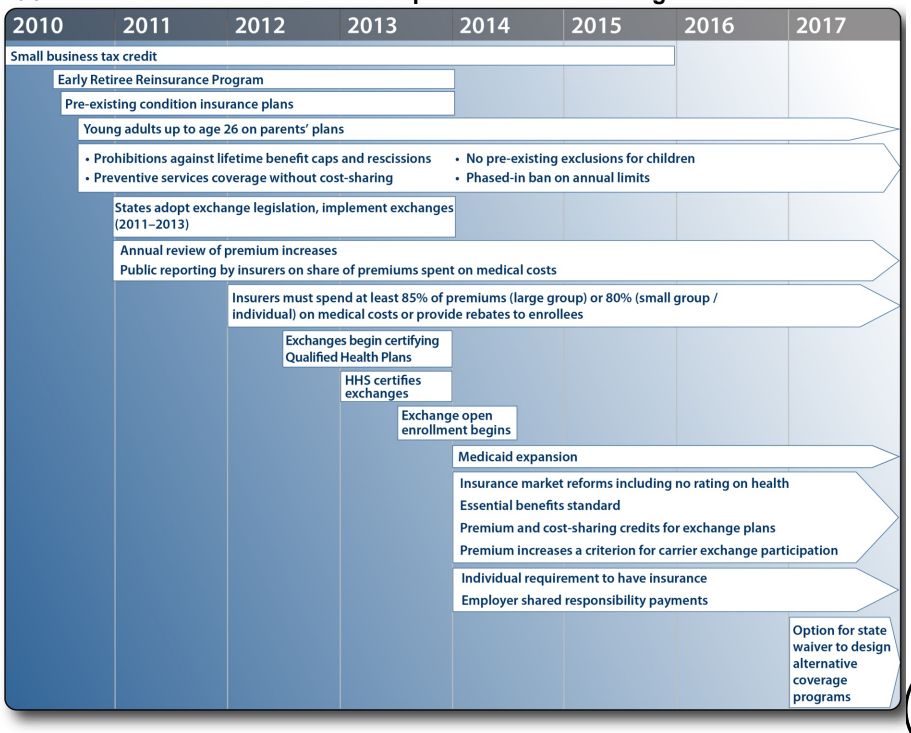
Exhibit 12. Timeline for Health Reform Implementation: Coverage Provisions



Source: National Association of Insurance Commissioners; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111–148 and 111–152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

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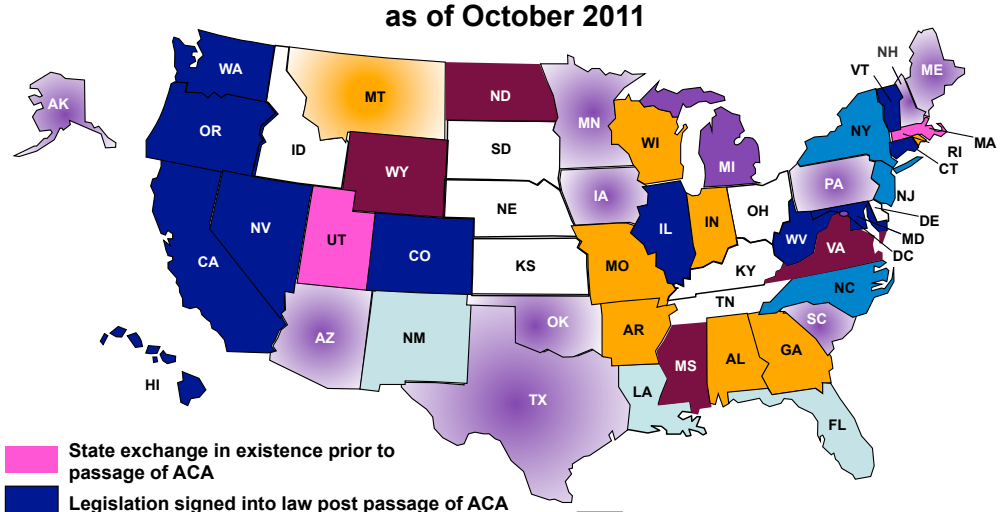
Exhibit 13. Status of State Legislation to Establish Exchanges, as of October 2011



- State exchange in existence prior to passage of ACA
- Legislation signed into law post passage of ACA
- Legislation signed: intent to establish an exchange, creation of study panel or appropriation
- Legislation passed one or both houses
- Legislation pending in one or both houses
- Pending legislation failed
- Governors pursuing non-legislative options
- Governors working with HHS on options
- Governor veto or decision not to establish exchange

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Source: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database, http://www.ncsl.org/default.aspx?TabId=22122; Politico.com; Commonwealth Fund analysis.

Exhibit 14. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: Silver plan
<133%	S: <$14,484 F: <$29,726	2% (or Medicaid)	S: $1,983 F: $3,967	94%
133%–149%	S: $16,335 F: $33,525	3.0%–4.0%		94%
150%–199%	S: $21,780 F: $44,700	4.0%–6.3%		87%
200%–249%	S: $27,225 F: $55,875	6.3%–8.05%	S: $2,975 F: $5,950	73%
250%–299%	S: $32,670 F: $67,050	8.05%–9.5%		70%
300%–399%	S: $43,560 F: $89,400	9.5%	S: $3,967 F: $7,933	70%
≥400%	S: ≥$43,560 F: ≥$89,400	—	S: $5,950 F: $11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
2nd tier (Silver) actuarial value: 70%
3rd tier (Gold) actuarial value: 80%
4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people who cannot find plan with premium <=8% of income

Notes: In the income and out-of-pocket limits columns, S refers to single and F refers to family. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.
Source: Federal poverty levels are for 2011; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

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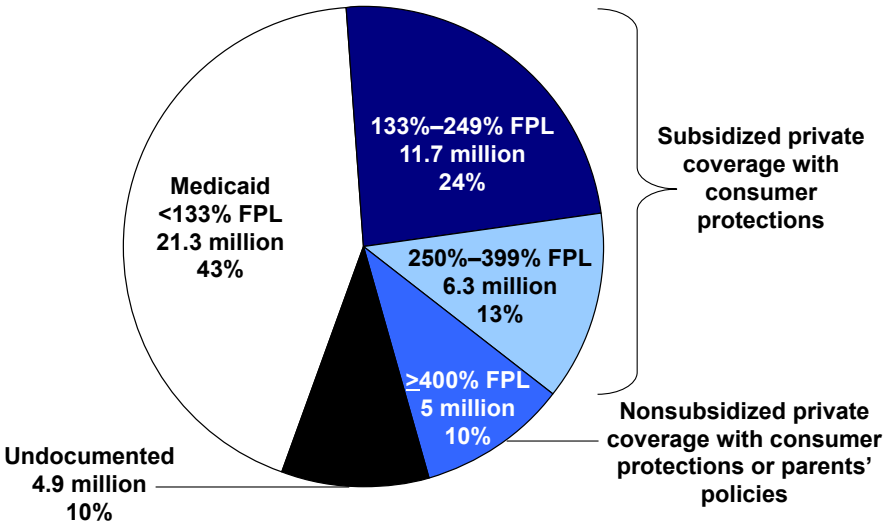
Exhibit 15. Distribution of Uninsured Nonelderly Individuals in 2010, by Income Level and Provisions of the Affordable Care Act



49.1 million uninsured individuals, ages 0–64

Note: FPL refers to federal poverty level.
Source: Analysis of the March 2011 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

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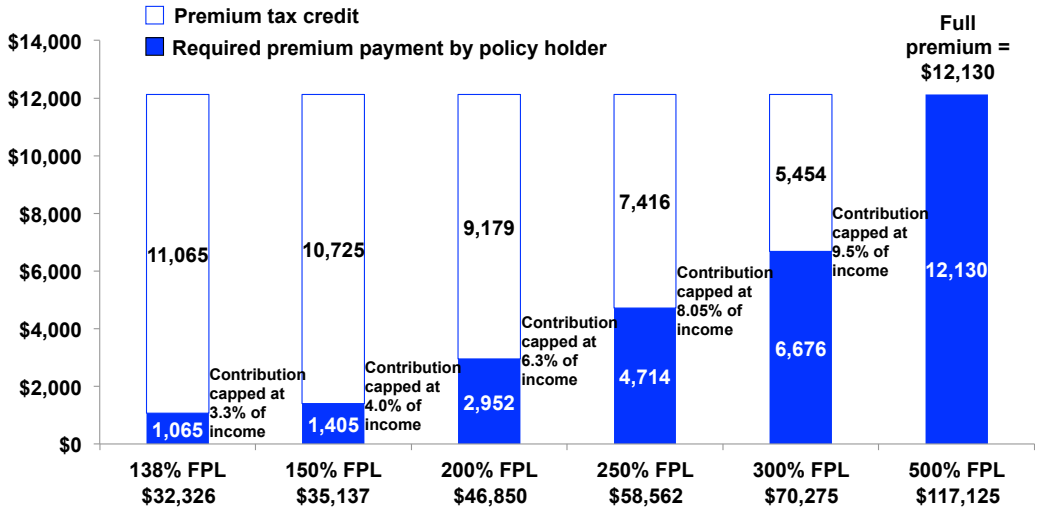
Exhibit 16. Annual Premium Amount and Tax Credits for a Family of Four Under the Affordable Care Act, 2014

Annual premium amount paid by policy holder and premium tax credit*



* For a family of four, policy holder age 40, in a medium-cost area in 2014. Premium estimates are based on an actuarial value of 0.70.
Actuarial value is the average percent of medical costs covered by a health plan. FPL refers to federal poverty level.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator, http://healthreform.kff.org/Subsidycalculator.aspx.

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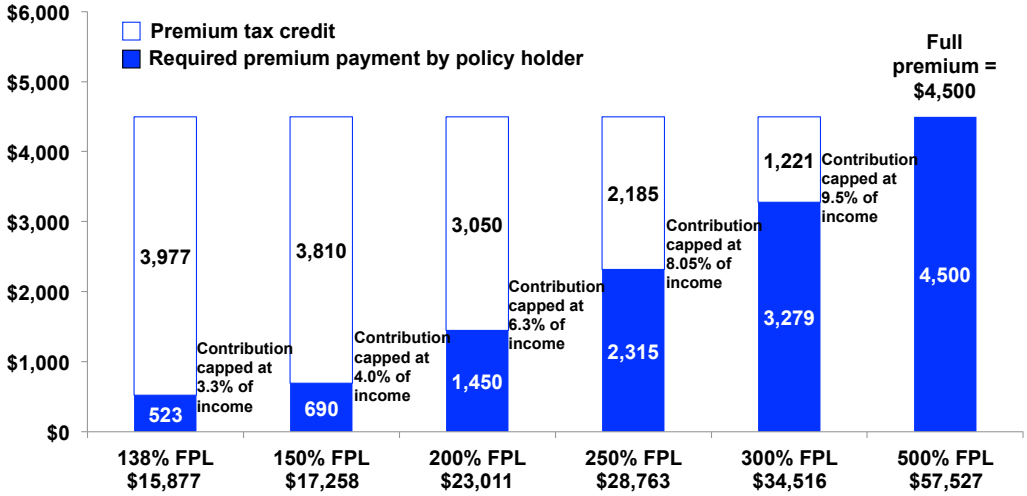
Exhibit 17. Annual Premium and Tax Credits for a Single Adult Under the Affordable Care Act, 2014

Annual premium amount paid by policy holder and premium tax credit*



* For a single adult, age 40, in a medium-cost area in 2014. Premium estimates are based on an actuarial value of 0.70. Actuarial value is the average percent of medical costs covered by a health plan. FPL refers to federal poverty level.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator, http://healthreform.kff.org/Subsidycalculator.aspx.

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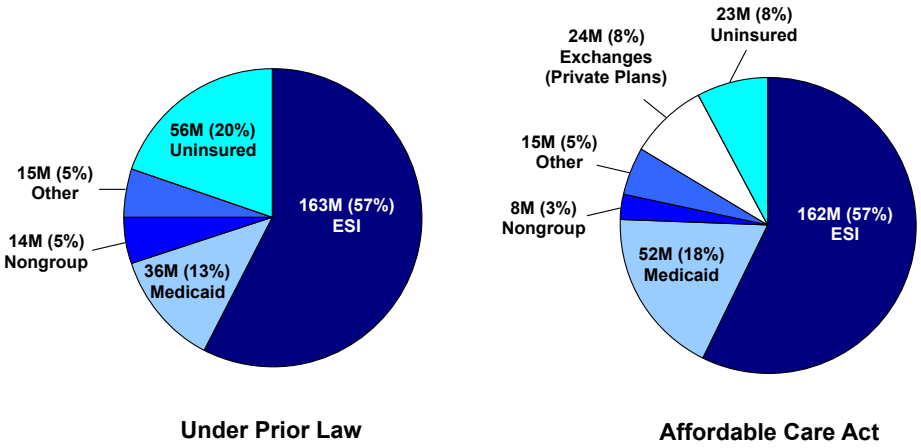
Exhibit 18. Source of Insurance Coverage Pre-Reform and Under the Affordable Care Act, 2020



Among 284 million people under age 65

Notes: Employees whose employers provide coverage through the exchange are shown as covered by their employers. ESI refers to employer-sponsored insurance. "Other" includes Medicare.
Source: Testimony Statement of Douglas W. Elmendorf, Director, before the Subcommittee on Health Committee on Energy and Commerce U.S. House of Representatives, CBO's Analysis of the Major Health Care Legislation Enacted in March 2010, March 30, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

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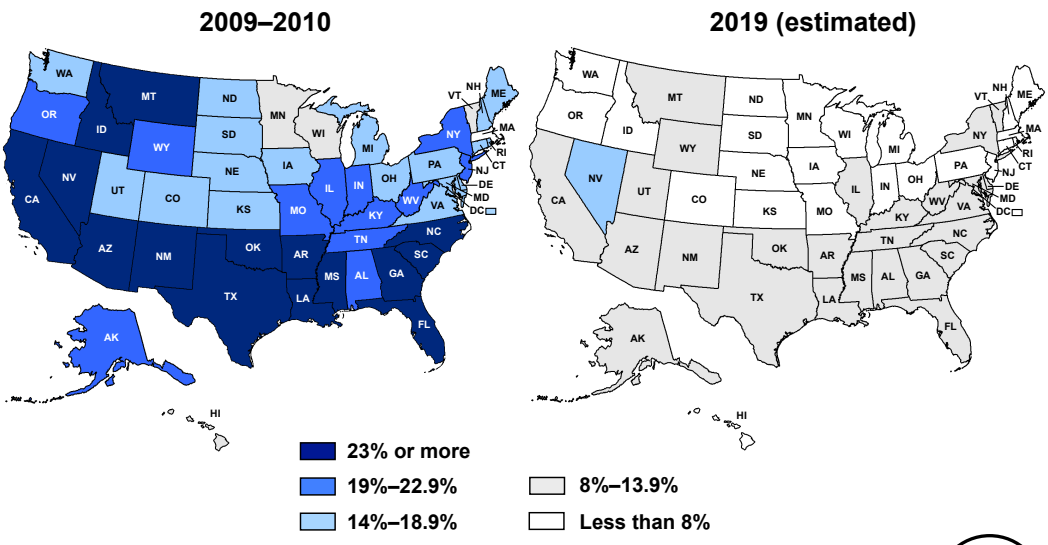
Exhibit 19. Post-Reform: Projected Percent of Adults Ages 19–64 Uninsured by State



Data: U.S. Census Bureau, 2010–11 Current Population Survey ASEC Supplement; estimates for 2019 by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

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Exhibit 20. Estimated Budgetary Effects of Enactment of the Affordable Care Act and the Health Care Provisions of the Reconciliation Act, 2012–2021

Dollars in billions

	Revised February 2011 CBO Estimate
Total Net Impact on Federal Deficit, 2012–2021	**–$124**
Total Federal Cost of Coverage Expansion and Improvement	**$1,151**
Gross Cost of Coverage Provisions	***$1,390***
• Medicaid/CHIP outlays	674
• Exchange subsidies	677
• Small employer subsidies	40
Offsetting Revenues and Wage Effects	***–$239***
• Payments by uninsured individuals	–27
• Play-or-pay payments by employers	–82
• Associated effects on taxes and outlays	–130
Total Savings from Payment and System Reforms	**–$646**
Total Revenues	**–$631**
• Excise Tax on High-Premium Insurance Plans	–111

Note: Totals do not reflect net impact on deficit because of rounding. Discontinuing the CLASS program eliminates an estimated $86 billion of the $732 billion in payment and system reform savings the health reform law was projected to generate over 2012–2021.
Source: D. Elmendorf, *Letter to the Honorable John Boehner* (Washington: Congressional Budget Office, Feb. 18, 2011).

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Exhibit 21. Comparison of CMS 2009, 2010, and 2011 National Health Expenditure (NHE) Spending Projections

		Total NHE ($ billions)	% difference from 2009	NHE per capita	NHE/ GDP	NHE CAGR 2015–2020
2020	2009 CMS estimate without reform*	$4,912.5		$14,517.0	21.0%	6.8%
	2010 CMS estimate without reform**	$4,757.6	–3.2%	$14,059.0	20.3%	6.7%
	2010 CMS estimate with reform**	$4,861.1	–1.0%	$14,365.0	20.8%	6.6%
	2011 CMS estimate without reform	$4,564.3	–7.1%	$13,487.9	19.5%	6.4%
	2011 CMS estimate with reform	$4,638.4	–5.6%	$13,708.8	19.8%	6.3%

Notes: * Assumes 10-year 2009–2018 NHE CAGR continues in 2019 and 2020;
** Assumes 10-year 2010–2019 NHE CAGR continues in 2020.
Sources: K. Davis, "Health Spending Continues to Moderate, Cost of Reform Overestimated," Commonwealth Fund Blog, July 29, 2011; CMS Spending Projections from 2009, 2010, and 2011; Commonwealth Fund estimates.

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Exhibit 22. The Number of Adults Without Insurance, Forgoing Health Care Because of Cost, and Paying Large Shares of Their Income on Health Care Has Increased, 2001–2010

Adults ages 19–64

	2001	2005	2010
In the past 12 months:			
Uninsured any time during the year	**24% 38 million**	**28% 48 million**	**28% 52 million**
Any bill problem or medical debt*	**—**	**34% 58 million**	**40% 73 million**
Any cost-related access problem**	**29% 47 million**	**37% 64 million**	**41% 75 million**
Spent 10% or more of household income on premiums***	**11% 10 million**	**14% 14 million**	**15% 14 million**
Spent 10% or more of household income on premiums and total out-of-pocket costs******	**21% 31 million**	**23% 35 million**	**32% 49 million**
Any of the above	**—**	**62% 107 million**	**67% 123 million**

* Includes: Had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills being paid off over time. ** Includes any of the following due to cost: Had a medical problem, did not visit doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get needed specialist care. *** Base: Respondents who reported their income level and premium costs for their private insurance plan **** Base: Respondents who specified income level and private insurance premium/out-of-pocket costs for combined individual/family medical expenses.
Source:S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

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Sara R. Collins, Ph.D., is vice president for Affordable Health Insurance at the Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, Dr. Collins has led several national surveys on health insurance and authored numerous reports, issue briefs and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: SARA R. COLLINS

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2008. Include the source and amount of each grant or contract.

I have not received any federal grants or contracts since Oct. 1 2008.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

I certify that the above information is true and correct.

Signature:

Date: 10.26.11