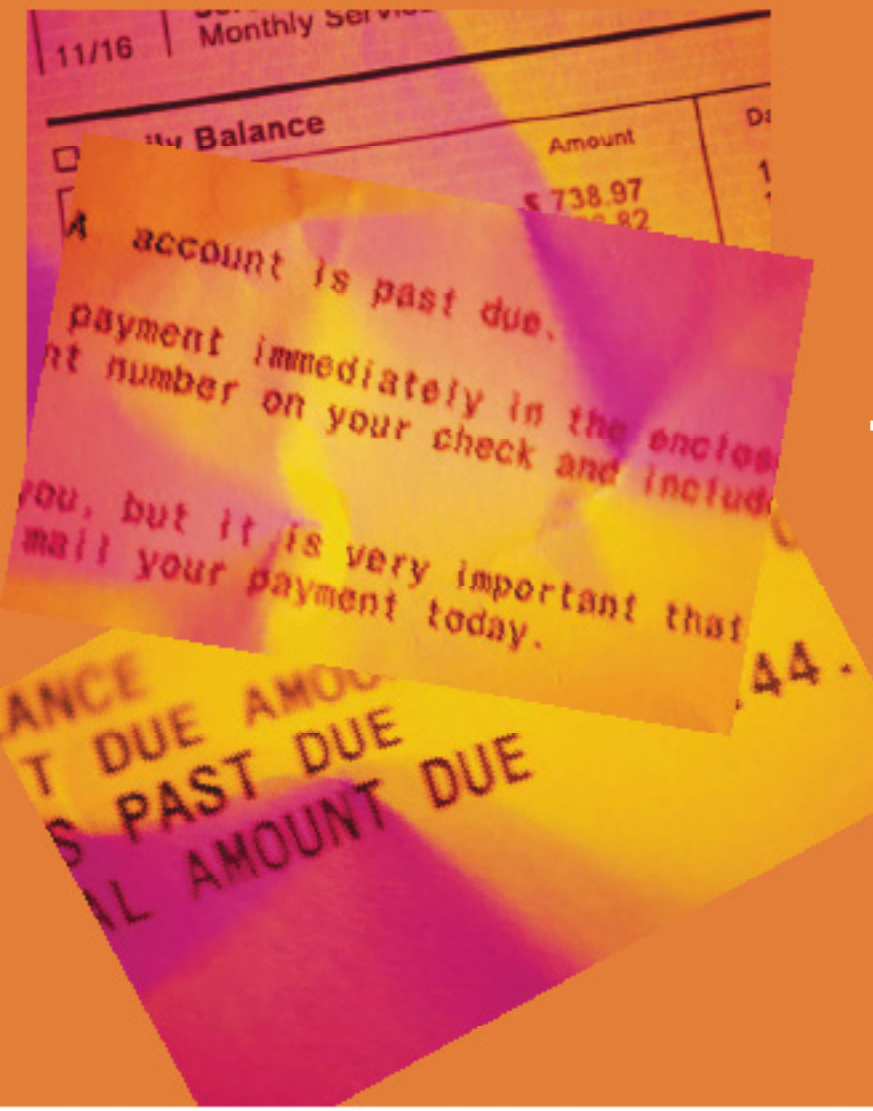

The Bottom Line:

How the Affordable Care Act Helps Nebraska Families

Families USA

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Over the last two decades, paying health insurance premiums and other health care bills has become increasingly hard for Nebraska families. As premiums have gone up each year and the cost of health care has escalated, more and more costs have been shifted to consumers through increases in deductibles and copayments and decreases in covered services. Middle-class and low-income families need relief from escalating health care costs. The Affordable Care Act, when fully implemented, will provide tangible and measurable relief to Nebraska families.

First, the Affordable Care Act will provide direct financial relief to hundreds of thousands of *insured* Nebraska families that struggle to pay health insurance premiums today. The new law will give families the option to shop for a plan in new state insurance marketplaces (called "exchanges") and to receive a robust discount on their premiums (through a refundable "premium tax credit"). The Affordable Care Act will also help people who have insurance by protecting them from high deductibles, high copayments, and unexpected gaps in their insurance coverage in three ways: It will eliminate lifetime and annual limits on how much a health insurance plan will pay for covered benefits (so that plan payments don't abruptly "run out"), it will cap how much a person must spend each year on deductibles and copayments for covered benefits, and it will provide additional help with out-of-pocket costs for lower-income families.

Second, the Affordable Care Act will help Nebraska families who are *uninsured* today by expanding affordable insurance options. Both the new premium tax credits and an expansion of Medicaid will provide new coverage options to families who could not afford coverage before. The Medicaid program will be available to families with incomes at or below 133 percent of the federal poverty level (about $30,000 in annual income for a family of four). For people with incomes above that level and up to 400 percent of poverty (about $90,000 for a family of four), the new premium tax credits will be there to help them afford coverage. And reducing the number of uninsured will reduce the "hidden health tax" that is imposed on insured families in the form of higher premiums to pay part of the cost of care provided to the uninsured.

Third, the Affordable Care Act will slow the growth of underlying health care costs and thus help all Nebraskans. The new law contains a range of common-sense provisions that will both improve quality and bring down the growth in health care costs. The Affordable Care Act authorizes programs that improve the ways that doctors and hospitals coordinate care, programs that promote preventive services and practices, and programs that will develop and disseminate better information about new drugs and treatments to both patients and doctors. In addition, the Affordable Care Act will promote transparency, accountability, and competition among health insurance companies through both the new state exchanges and new standards for reviewing how premiums are set by insurers. By promoting greater competition and accountability, the Affordable Care Act will motivate

insurance companies to hold down health care costs and premium increases while improving quality of care.

To measure the *net* bottom line impact of the Affordable Care Act on family budgets, our analysis used a sophisticated economic model built on publicly available data that was able to look simultaneously at all of the major provisions of the Affordable Care Act and to measure their impact on families in 2019. (Detailed descriptions of the methodology and model inputs are available online at www.familiesusa.org/resources/publications/reports/the-bottom-line.html.) We used the year 2019 for our analysis in order to capture the effects of the Affordable Care Act when it is fully implemented. Many key provisions of the new law go into effect in 2014, and providing a five-year window for implementation allows us to capture both full enrollment in programs that expand coverage and the effects of initiatives that are designed to slow the growth in health care costs.

Our examination found that both lower- and middle-income families will be financial winners, and both *uninsured* and *insured* families will come out ahead.

Key Findings

Health Reform: A Boon to Families and the Economy

- On average, each household in Nebraska will be $1,838 better off in 2019 due to the provisions of the Affordable Care Act (Table 1).
- Households with income of less than $100,000 will receive the greatest financial benefit (Table 1).
  - Households with income under $30,000 will be $3,661 better off.
  - Households with income between $30,000 and $50,000 will be $2,353 better off.
  - Households with income between $50,000 and $100,000 will be $1,356 better off.

Table 1.

Net Financial Effect of the Affordable Care Act for Nebraska Families, by Household Income, 2019

Household Income	Number of Households	Net Financial Effect Per Household
$0-$30,000	196,000	$3,661
$30,000-$50,000	114,500	$2,353
$50,000-$100,000	209,100	$1,356
$100,000-$250,000	198,600	$797
$250,000+	31,400	-$1,609
Total*	**749,600**	**$1,838**

* Numbers may not add due to rounding.

Health Reform Means Lower Premiums and Help with the Cost of Coverage

- The Affordable Care Act will make health coverage more affordable for Nebraska families in two ways: by helping to stem the rise in health insurance premiums, and by extending help with the cost of coverage to lower- and middle-income families. These provisions will help both those with coverage today and those who are uninsured.
- Under health reform, previously insured families will pay an average of $860 less in premiums in 2019 (Table 2a).
- Previously insured lower- and middle-income households will benefit from the greatest reductions in premiums (Table 2a).
  - Households with income under $30,000 will pay $816 less in premiums.
  - Households with income between $30,000 and $50,000 will pay $1,347 less in premiums.
  - Households with income between $50,000 and $100,000 will pay $1,088 less in premiums.

Table 2a.

Savings on Health Insurance Premiums for Previously Insured Households in Nebraska, by Household Income, 2019

Household Income	Number of Previously Insured Households	Savings on Premiums Per Household
$0-$30,000	110,300	$816
$30,000-$50,000	77,000	$1,347
$50,000-$100,000	176,600	$1,088
$100,000-$250,000	187,200	$514
$250,000+	29,800	$592
Total*	**580,900**	**$860**

* Numbers may not add due to rounding.

- Previously uninsured lower- and middle-income households will receive substantial help with the cost of health coverage (see Table 2b on page 4).
  - Households with income under $30,000 will receive an average of $6,291 in help with the cost of health coverage.
  - Households with income between $30,000 and $50,000 will receive an average of $4,861 in help with the cost of health coverage.
  - Households with income between $50,000 and $100,000 will receive an average of $2,559 in help with the cost of health coverage.

Table 2b.

Value of Federal Assistance with Health Coverage for Previously Uninsured Households in Nebraska, by Household Income, 2019

Household Income	Number of Previously Uninsured Households	Federal Assistance With Health Coverage Per Household
$0-$30,000	85,700	$6,291
$30,000-$50,000	37,400	$4,861
$50,000-$100,000	32,500	$2,559
$100,000+	13,000	$619
Total*	**168,700**	**$4,817**

* Numbers may not add due to rounding.

Health Reform Means Lower Out-of-Pocket Costs

- On average, households in Nebraska will spend $209 less out of pocket under the Affordable Care Act in 2019 than they would have without reform (Table 3).
- Lower- and middle-income households will benefit from the greatest reductions in out-of-pocket spending (Table 3).
  - Households with income under $30,000 will spend an average of $376 less out of pocket on health care.
  - Households with income between $30,000 and $50,000 will spend an average of $291 less on out-of-pocket costs.
  - Households with income between $50,000 and $100,000 will spend an average of $140 less on out-of-pocket costs.

Table 3.

Reduction in Out-of-Pocket Spending in Nebraska, by Household Income, 2019

Household Income	Number of Households	Reduction in Out-of-Pocket Spending Per Houshold
$0-$30,000	196,000	$376
$30,000-$50,000	114,500	$291
$50,000-$100,000	209,100	$140
$100,000-$250,000	198,600	$90
$250,000+	31,400	$71
Total*	**749,600**	**$209**

* Numbers may not add due to rounding.

Discussion

To measure the net bottom line impact of the Affordable Care Act (ACA) on family budgets in Nebraska, Families USA contracted with Dr. Jonathan Gruber, Professor of Economics at the Massachusetts Institute of Technology. Dr. Gruber's economic model, built on publicly available data, allowed us to input multiple policy variables, and to model individual and employer behavior in response to these policies. The model also allowed our analysis to look at the economic impact on households at different income levels. For our analysis, we looked at the economic impact of the Affordable Care Act when the law is more fully implemented in 2019, five years after many provisions have gone into effect. By 2019, the law's new programs that expand coverage will have had an opportunity to achieve close to full enrollment. Likewise, multiple provisions that are designed to slow the growth of health care costs and improve quality of treatment will have had an opportunity to work. (A full description of the methodology, including details about the model and inputs, is available online at www.familiesusa.org/resources/publications/reports/the-bottom-line.html.)

To achieve the goal of lowering household spending on health insurance and medical bills, the Affordable Care Act has provisions that fall into three major categories. The discussion that follows highlights these provisions.

1. **Direct Financial Relief**
   The Affordable Care Act will provide direct financial relief to millions of *insured* families that struggle to pay for health insurance premiums and the out-of-pocket health care costs that insurance doesn't cover (deductibles, copayments, and uncovered care). The new law provides this help through robust premium tax credits, as well as cost-sharing assistance and new out-of-pocket spending limits. Not only will insurance be more affordable, but it will be there for families when they need it—without the holes in coverage that are so often concealed in fine print.

2. **Health Coverage for More Americans**
   The Affordable Care Act will provide new coverage to millions of currently *uninsured* Americans. Both the new premium tax credits and an expansion of Medicaid will provide new coverage to families who could not afford it before. Under the new law, Medicaid coverage will generally be available for families with annual incomes at or below 133 percent of the federal poverty level (about $30,000 for a family of four in 2011), and the new premium tax credits will be there to help families with incomes between 133 and 400 percent of poverty (about $90,000 for a family of four in 2011). For all families, these programs will be an important cushion when layoffs or other events leave families without affordable job-based coverage.

3. **Controlling Costs**
   The new law contains provisions that will slow the growth of health care costs for all Americans. It includes a broad range of initiatives to promote prevention, improve quality, and contain health care costs by looking at how we pay providers and how we coordinate care so that patients receive appropriate services. The new law will also promote competition among insurance plans, which will ultimately drive them to adopt innovations to improve cost and quality.

Of course, these provisions in the Affordable Care Act will reduce the burden of health care costs on family budgets. For example, as provisions in the new law reduce underlying health care costs, the cost of health insurance will go down, and families will save money on premiums. Lower premiums also will mean that more people can afford to purchase coverage. As more people move from the ranks of the uninsured to the insured, premiums should further decline as the hidden health tax is reduced. In 2008, this hidden health tax raised family health premiums by more than $1,000.[1]

Health Insurance Premium Tax Credits

The Affordable Care Act will provide much-needed financial relief to millions of lower- to middle-income individuals and families through a robust new tax credit to assist with the cost of health insurance premiums. These new premium tax credits will offset a significant portion of the cost of health insurance premiums. The unique tax credit will be calibrated to ensure that individuals and families do not have to spend an excessive share of their income on premiums. The limit for each family will be between 2 and 9.5 percent of income, on a sliding scale. (See “Calculating the Size of the Premium Tax Credit” on page 15 for details.)

Generally, the premium tax credits will be available to individuals and families who have incomes between 133 and 400 percent of poverty (between about $14,500 and $44,000 for an individual, and between about $30,000 and $90,000 for a family of four in 2011) to help with the cost of health insurance premiums for coverage that is purchased through the new consumer-friendly state health insurance marketplaces, or “exchanges.” People who have an offer of coverage from their employer may be eligible for a premium tax credit if they would have to pay more than 9.5 percent of their household income to buy a plan, or if their employer’s plan pays less than 60 percent of the cost of covered benefits (on average).

While the Affordable Care Act will deliver the premium subsidy through a tax credit mechanism, technically, this financial help will not work like many other tax credits: Families with low incomes who do not owe taxes will still receive help with the cost of premiums. In addition, families will not need to wait until their taxes have been filed and processed in order to receive the tax credit and enroll in coverage. Instead, the tax credit will be available to pay the premium at the time the person enrolls in a plan.

The new premium tax credits will provide much-needed assistance to insured individuals and families who struggle to pay rising premiums and to uninsured individuals and families who need help to be able to purchase coverage. In fact, of the approximately 28.6 million Americans who will be eligible for the premium tax credits in 2014, more than half (52 percent) are currently insured. Among all the individuals who will be eligible for the premium tax credits, two-thirds will be in working families with annual incomes at or above 200 percent of poverty (above about $45,000 for a family of four). More than half of those who will be eligible for the premium tax credit are in families with a primary worker who is employed by a small business with fewer than 100 employees.[2]

Protections on Out-of-Pocket Spending

Over the last two decades, health care spending has risen rapidly, driving an increase in insurance premiums. In reaction to rising premiums, employers and individuals have been forced to try to hold down premium costs by moving to skimpier health insurance plans—plans that cover fewer benefits, that pay a smaller share of the benefits that they do cover, or that limit how much the insurer will pay for health care. As a result, even for those with insurance, a growing portion of their family budget is spent on out-of-pocket health care costs—costs that can become catastrophic. This will end under the Affordable Care Act. Not only does it address the growth in health care costs and provide premium tax credits, but it also protects family budgets from high out-of-pocket spending. It is estimated that the number of people who are "underinsured," that is, who have high medical costs as a share of their income, will be cut by 70 percent due to the provisions in the Affordable Care Act.[3]

The Affordable Care Act provides protection from high out-of-pocket spending in three ways:

1. by eliminating lifetime and annual limits on how much a health insurance plan will pay for covered benefits (so that plan payments don't abruptly "run out");
2. by capping how much a person must spend each year on deductibles and copayments for covered benefits; and
3. by providing additional help to lower-income families to further reduce their out-of-pocket spending on deductibles and copayments through cost-sharing subsidies.

These protections will reassure people with insurance that their health coverage will be there for them when they need it and will better protect their family budgets from high medical bills. The inability to pay a medical bill can have catastrophic consequences: It can result in long-term damage to a family's credit rating and harm their ability to meet financial needs now and in the future. Insured consumers will no longer have to worry that one serious illness or accident could wipe out their family's economic security. (For details, see "Three-Way Protection from Out-of-Pocket Spending: Insurance That Truly Has You Covered" on page 16).

Medicaid: Expanding the Health Care Safety Net for Hard Times

In addition to the new premium tax credits, the Affordable Care Act will increase the number of people who have affordable health coverage by expanding Medicaid.

Most people do not realize that many people with low incomes are not eligible for Medicaid. In every state, children in families with incomes up to at least 200 percent of poverty (about $45,000 for a family of four in 2011) are eligible for either Medicaid or the Children's Health Insurance Program (CHIP), but the story is very different for their parents. The median income limit for Medicaid eligibility for parents is 64 percent of poverty (about $14,000 for a family of four in 2011). Furthermore, in most states, adults without dependent children can literally be penniless and not qualify for Medicaid: Only 11 states currently provide any Medicaid coverage to childless adults.

Beginning in 2014, Medicaid will be available to all adults with incomes at or below 133 percent of poverty (about $30,000 for a family of four in 2011), whether they have dependent children or not. The costs of this expanded coverage will be paid for in full by the federal government for the first three years, and then the federal share will gradually decline until the federal government pays 90 percent and the states pay 10 percent. This is much less than the share paid by states now to cover current Medicaid enrollees.

This expansion and simplification of Medicaid will allow it to be a true safety net for people who are facing hard economic times and who have no other way to get health coverage. Medicaid is critically important during an economic downturn, when people often lose health coverage if they lose their jobs, or if coverage becomes too expensive to maintain when their family's income declines.[4]

Reducing the Growth of Health Care Costs

The Affordable Care Act authorizes multiple initiatives and demonstration projects that are designed to address the need for changes in our health care system to improve quality and treatment and to reduce the rise in health care costs. It works to bring down costs through not just one solution, but through a host of efforts that focus on doctors, hospitals, insurance companies, employers, and patients. Unlike other approaches to reducing health care costs, these provisions do not resort to simply reducing payments for health care services or shifting costs to consumers through higher deductibles and copayments. Rather, the aim of these provisions is to provide higher-quality care more efficiently and with less waste.

The Affordable Care Act's cost and quality provisions reflect common-sense approaches to improving our nation's health care system. These provisions fall into the following categories:

1. provisions designed to test ways that doctors and hospitals can better talk to each other and coordinate care, especially for people with chronic health problems like diabetes or congestive heart failure,
2. provisions that promote preventive services so costly health care conditions and complications can be avoided or treated sooner,
3. provisions that promote the sharing of unbiased information with doctors and patients about which medical treatments work and which don't, and
4. provisions to create a health care system that delivers better value for the dollar by allowing real competition among health insurance companies in more transparent and consumer- and business-friendly insurance marketplaces.

1. Provisions that Promote Improved Care Coordination

Better coordination of care can not only improve the overall quality of care that is provided to patients, but it can also save money. The fragmented nature of our health care system leads, for example, to the unnecessary duplication of tests and procedures. A patient may have a blood test ordered by his or her primary care physician, then have the same test repeated by a specialist, then report to a hospital for treatment and have to repeat the same test. This redundancy, created by fragmentation, is compounded by our payment system. Both private insurers and public programs such as Medicare usually pay providers for each individual service they provide to a patient. This is known as "fee-for-service" reimbursement, and it means that the more services they provide, the more money they are paid. This incentive to provide more care is a major contributor to rising health care costs.

Coordinating care is especially important for people with chronic health problems. The cost of treating patients with chronic diseases consumes three out of every four health care dollars spent in the United States.[5] Through better care coordination, much of the pain and excess costs associated with this care can be prevented. For example, regular access to comprehensive foot care for people with diabetes can reduce amputation rates by 45-85 percent.[6] When diabetes goes untreated and a patient ends up with an amputation, the costs for long-term home care or nursing home care in dollars and in human suffering are enormous—much greater than the cost of regular foot exams and good foot care.

Other ideas that will be tested under the Affordable Care Act include "bundling health care payments" and "value-based purchasing." Bundling is exactly what it sounds like: a way to "bundle" a package of related services and to pay one fee rather than paying separately for each and every test, exam, and treatment. For example, the cost of x-rays and scans of the knee before knee replacement surgery, all the direct costs related to the surgery, and the post-operative rehabilitation services could be bundled so that only one payment would be made. Bundling of payments gives incentives to doctors, hospitals, and even post-hospital providers to work together and provide cost-effective care. "Value-based purchasing" rewards doctors and hospitals by adjusting payments based on whether they meet certain quality standards (in the knee surgery example, the standards might address the procedures used to evaluate the knee before surgery and infection control practices used during and after surgery). Combined, the goal of these two strategies is to move our health care system toward paying for value and quality, not just volume.

2. Provisions that Promote Prevention

Another category of common-sense provisions in the Affordable Care Act that can help drive down the growth of health care costs emphasizes prevention. For example, the law eliminates deductibles and copayments for preventive services in Medicare and private coverage (preventive services include tests such as mammograms, Pap tests, colorectal cancer screening, diabetes screenings, autism screenings for children, as well as wellness check-ups and immunizations). Again, if health problems are identified earlier, before they turn into more serious conditions, significant dollars can be saved.

Another common-sense prevention initiative focuses on reducing hospital-related infections. The idea is to give incentives to doctors, nurses, and others to follow simple procedures that can significantly reduce avoidable infections that are acquired during a hospital stay. Nationally, one in 20 patients admitted to a U.S. hospital develops an infection—an estimated 1.7 million patients develop an infection each year.[7] These costly infections can be prevented through inexpensive steps: for example, promoting and monitoring hand washing, changing IV dressings when damp, and minimizing the frequency of operating doors being opened during surgeries.[8]

Reducing health care costs and improving quality come together in another initiative to prevent avoidable hospital readmissions by improving communication between patients and doctors, as well as by creating incentives for hospitals to provide good discharge planning services. These services help patients understand how to take prescribed drugs, make sure that follow-up treatments and check-ups are scheduled, and ensure that the home environment will allow a patient to recover safely (and, if needed, arrange home services that can assist the patient).

3. Provisions for Sharing Unbiased Information about What Works

Currently, too much money is spent on health care treatments that are expensive and ineffective. Every day, new drugs and treatments are identified; they may be life-saving breakthroughs, or they may have little benefit to patients. Busy doctors must struggle to stay abreast of such new developments, and too often, they rely on research that is funded by pharmaceutical companies and device manufacturers. Doctors should make diagnosis and treatment decisions based on scientific research and unbiased information.

Doctors need a central, easy-to-access source of research so that their patients don't miss out on a cutting-edge new therapy or waste money on something that may sound new and exciting in an advertisement but that offers little value. Such a centralized source of comparative information and research for doctors should not only look at how a new drug or treatment works, but also at how well it works compared to existing drugs or treatments. It should look at what kinds of patients can benefit from a new drug or treatment and which patients may find it less helpful or even harmful. Currently, a company that wants to sell a new drug or device has to prove only that its product is safe and effective for some people, but the company does not have to look at whether the product is better than existing therapies and, if so, for which patients.

To address this lack of appropriate research on new drugs and treatments, the Affordable Care Act created an independent, nonprofit research entity called the Patient-Centered Outcomes Research Institute. This new institute is charged with conducting research on what drugs and treatments work best for which patients and filling in gaps in medical evidence so doctors have the information they need to provide the best possible care to their patients.

4. Provisions that Promote Better Value for the Dollar through the Creation of Competitive Insurance Marketplaces

The Affordable Care Act has three key initiatives that will increase transparency and promote competition among private insurance plans, described below:

The law creates new rate review processes that will require health insurance companies to clearly explain how they set premiums and ensure that states have robust rate review systems that can deny unreasonable premium rates or requests for increases. The law has already provided federal grants to states to strengthen their capacity to review health insurance premiums and requests for increases. If a state and the Secretary of Health and Human Services (HHS) find premium increases to be unreasonable, they can bar a plan from participating in an exchange.

The law creates new standards governing the percentage of premium dollars that must go to pay for health care services rather than to insurance company profits, CEO salaries, or other overhead. Health plans must already meet new medical loss ratio (MLR) standards set out in the Affordable Care Act. These standards require plans to account for their expenses in the following three categories: medical and clinical costs, expenditures to improve the quality of care, and all other costs. If a plan has not spent an adequate share of premium dollars (80 percent for individual and small group plans, 85 percent for large group plans) on the first two categories of expenses, the plan will be required to pay rebates to enrollees. Insurers will make the first round of rebates to consumers in 2012.

The law requires the establishment of state exchanges that, beginning in 2014, will provide regulated marketplaces where eligible consumers and small businesses can choose from a range of health insurance plans. In the new exchanges, insurance companies will have to clearly explain what care is covered and at what cost. This will help people shop for the best plan for the price, and it will promote competition among plans. And when insurance companies need to hold down premium increases and delivery higher quality in order to compete for customers, they can drive positive innovation in the delivery of health care.

Taken together, the new rate review processes in the states, the new medical loss ratio standards, and the new competitive marketplaces for health insurance will help drive insurance companies to find new and innovative ways to hold down premium increases and continue to deliver quality care in order to effectively compete for customers.

The Potential of the Affordable Care Act to Slow Growth in Health Care Costs

While it is difficult to fully assess the eventual impact of the Affordable Care Act provisions relating to cost and quality, it is safe to assume that the combination of initiatives described above will slow the growth of health care inflation. Health care economists have found that changes to our health care system have tremendous potential to reduce the growth in health care costs and, in turn, reduce premiums and out-of-pocket costs for consumers. For example, the Commonwealth Fund reviewed relevant literature published by several teams of economists that looked at the health care system reforms in the Affordable Care Act as it was developed in Congress. They reported that a 1.5 percentage point reduction in cost increases annually is realistic.[9]

While many of the cost and quality provisions in the Affordable Care Act started last year or this year, some will not be in place until 2014. Therefore, for our analysis, Families USA based our modeling on the Commonwealth Fund report's *most conservative* cost reduction assumption of only 1.0 percentage point per year *starting in 2014*.[10] We believe this assumption is reasonable and defensible.

Conclusion

Our analysis of the impact of the Affordable Care Act on the family budgets of Nebraska's lower- and middle-income families shows that Nebraskans will gain real and direct financial help from key provisions of the new law. For Nebraska families *with insurance*, the Affordable Care Act provides relief from double-digit growth in premiums, rapidly escalating deductibles and copayments, and arbitrary limits on what insurance plans cover. At the same time, tens of thousands of *uninsured* Nebraskans will have the peace of mind and financial security that comes with finally being able to buy quality health insurance for themselves and their families at a price they can afford. As our nation moves forward to tackle our economic challenges, now *is not* the time to eliminate the financial relief that the Affordable Care Act will provide to hard-working Nebraska families. Now *is* the time for states and the federal government to work together to implement the law so that these financial gains can be delivered to Nebraska families who have already waited too long for help with ever-growing health care costs.

Endnotes

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[10] Ibid.

Calculating the Size of the Premium Tax Credit

The size of the premium tax credit for which an individual or a family will be eligible will depend on the individual's or family's income. And how much coverage that tax credit will help buy will depend on the plan that is chosen. Below, we describe how income and plan choice come together to determine what an individual or family will have to pay out of pocket.

1. **Determine the size of an individual's or a family's premium tax credit.**
   Start with the family's income. The family's household income will be used to determine the maximum amount the family must pay toward premiums. This maximum amount (a maximum percentage of family income) will be set on a sliding scale based on income, with those with the lowest incomes paying the smallest proportion of their income on premiums.

2. **Identify the premiums for the second lowest-cost "silver" exchange plan that is available to the individual or family in the area in which they live.***
   This plan is the "silver reference plan," and the premium tax credit amount will be set so that the individual or family will not have to spend more than a specific percentage of their income on premiums for the silver reference plan. Premium limits are based on a sliding scale. At the lower end of the scale, families with incomes up to 133 percent of poverty (about $30,000 for a family of four in 2011) will pay a maximum of 2 percent of their income to purchase insurance, or about $595 annually. At the highest end of the scale, families with incomes between 300 and 400 percent of poverty (between about $67,000 and $90,000 for a family of four in 2011) will pay 9.5 percent of their income.

3. **Choose an individual or family plan that is available through an exchange.**
   The individual's or family's premium tax credit amount will be based on the premium for the silver reference plan. If a consumer selects a more expensive plan, he or she will pay the difference in price between this more expensive plan and the silver reference plan out of pocket. If a consumer selects a cheaper plan, he or she will still receive the premium tax credit based on the silver reference plan and thus will spend less out of pocket on the premiums for this cheaper plan.

An example illustrating the amount of assistance a family can get

The Johnsons, a family of four consisting of two adults and two children under the age of 18 with annual income of $33,525 (150 percent of poverty): If the annual premium for the silver reference plan for family coverage in the exchange in the Johnson's zip code is $10,000, the most the Johnson family would have to spend out of pocket on annual premiums to cover their family would be 4 percent, or about $1,341 (about $112 a month). The remainder of their premium for the silver reference plan would be covered by the premium tax credit of $8,659 (or that amount could be credited toward the premiums for a more or less expensive plan of their choice).**

* Plans that offer essential benefits can offer varying levels of coverage, labeled "bronze," "silver," "gold," and "platinum." These levels refer to the percentage of costs for a set of essential benefits that the plan would pay for an average enrollee: A bronze plan will pay for 60 percent of the cost of covered benefits, a silver plan will pay for 70 percent, a gold plan will pay for 80 percent, and a platinum plan will pay for 90 percent. These "actuarial values" are based on an average enrollee; the costs that the plan will pay and what is left for an individual to pay out of pocket for covered benefits will vary according to their health care utilization.

** Depending on the state, the children might be eligible for CHIP. Premiums for exchange coverage will likely be much higher than CHIP premiums.

Three-Way Protection from Out-of-Pocket Spending: Insurance that Truly Has You Covered

1 Lifetime and Annual Limits

Under the Affordable Care Act, insurance companies will no longer be allowed to set limits on the dollar amount of health benefits that they will cover in a single year or over the course of a person's lifetime. This means that consumers who pay for health coverage won't "run out" of coverage if they develop a health problem that is costly to treat.

The protection against lifetime limits took effect on September 23, 2010 (or later, depending on when a health plan year starts). The annual limits protection is being phased in between 2010 and 2014, with an initial requirement that plans have limits of no less than $750,000 per enrollee for essential benefits. That dollar amount will be raised to $1.25 million, then to $2 million, before being eliminated entirely as of January 1, 2014.

These protections apply to "essential benefits." Essential benefits include the following health care services: ambulatory care, such as doctor and specialist visits; emergency services; hospitalization; preventive and wellness services and chronic disease management; laboratory services; prescription drugs; maternity and newborn care; pediatric services; mental health and substance use disorder services; and rehabilitative and habilitative services and devices.

The lifetime limit protection applies to all insurance plans. The annual limit protections apply to everyone who gets coverage through a job and to people who purchase a new individual or family plan after March 23, 2010. The protection may also apply to a plan purchased before March 23, 2010, if the plan has made major changes in its coverage or substantially increased cost-sharing or deductibles.*

2 Out-of-Pocket Spending Caps

The Affordable Care Act also will help protect family budgets from high health care costs by establishing caps on out-of-pocket spending for health services that are included in the essential benefits package. This means that the amount an insured individual or family has to spend on deductibles, copayments, and co-insurance is capped.

The law sets the initial level of these new caps by tying them to an existing definition: the annual out-of-pocket spending limits for high-deductible health plans that are

associated with Health Savings Accounts (HSAs). If these caps went into effect in 2011, they would be $5,950 for individuals and $11,900 for families.

The Affordable Care Act will further reduce these out-of-pocket caps for families with incomes below 400 percent of the federal poverty level (about $90,000 for a family of four) who purchase coverage in the exchanges. If they were in effect in 2011, the caps would be reduced on a sliding scale (see table).

Out-of-Pocket Caps

Income	Cap for Individuals	Cap for Families
Between 100 and 200 percent of poverty	$1,983	$3,967
Between 200 and 300 percent of poverty	$2,975	$5,050
Between 300 and 400 percent of poverty	$3,967	$7,933

The caps apply to all insurance plans that are sold in the new state exchanges and all new plans that are sold in the individual and small group insurance markets. The caps may also apply to an existing plan if the plan has made major changes in its coverage or substantially increased cost-sharing or deductibles.**

In 2011, approximately 18.7 million Americans are in families with total medical bills that would exceed these out-of-pocket caps. The total dollar value of these medical bills is $48.0 billion.***

3 Cost-Sharing Subsidies

In addition to premium tax credits and sliding scale caps on out-of-pocket spending, the Affordable Care Act provides additional cost-sharing subsidies to individuals and families with incomes below 250 percent of poverty (about $56,000 for a family of four) who purchase a silver-level plan through the new state exchanges. These cost-sharing subsidies will increase the percentage of total health care costs that their health plans pay. The specifics of how these cost-sharing subsidies will work have not yet been detailed in regulations. For example, HHS could require plans to lower their deductibles or reduce copayments for eligible enrollees.

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* See Families USA, *Grandfathered Plans under the Patient Protection and Affordable Care Act* (Washington: Families USA, December 2010), available online at http://www.familiesusa.org/assetts/pdfs/health-reform/Grandfathered-Plans.pdf.

** Ibid.

*** Kim Bailey, Elisabeth Rodman, and Kathleen Stoll, *Worry Less Spend Less: Out-of-Pocket Spending Caps Protect America's Families* (Washington: Families USA, February 2011), available online at http://www.familiesusa.org/resources/publications/reports/health-reform/out-of-pocket-spending-caps.html.

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