Building A Healthier Nation
U.S. Health Reform: A Review

Swedish Association of Social Medicine

Stockholm, Sweden

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AMERICAN PUBLIC HEALTH ASSOCIATION
For science. For action. For health.

Objectives

1. Describe the U.S. health system
2. Why we did health reform
   - The "Patient Protection & Affordable Care Act" (ACA or Obamacare)
3. The ACA's outcomes to date & future challenges
4. APHA's health policy agenda

United States of America

- 321.4 million people
- Melting pot of cultures
- 3.797 million mi^2 land mass

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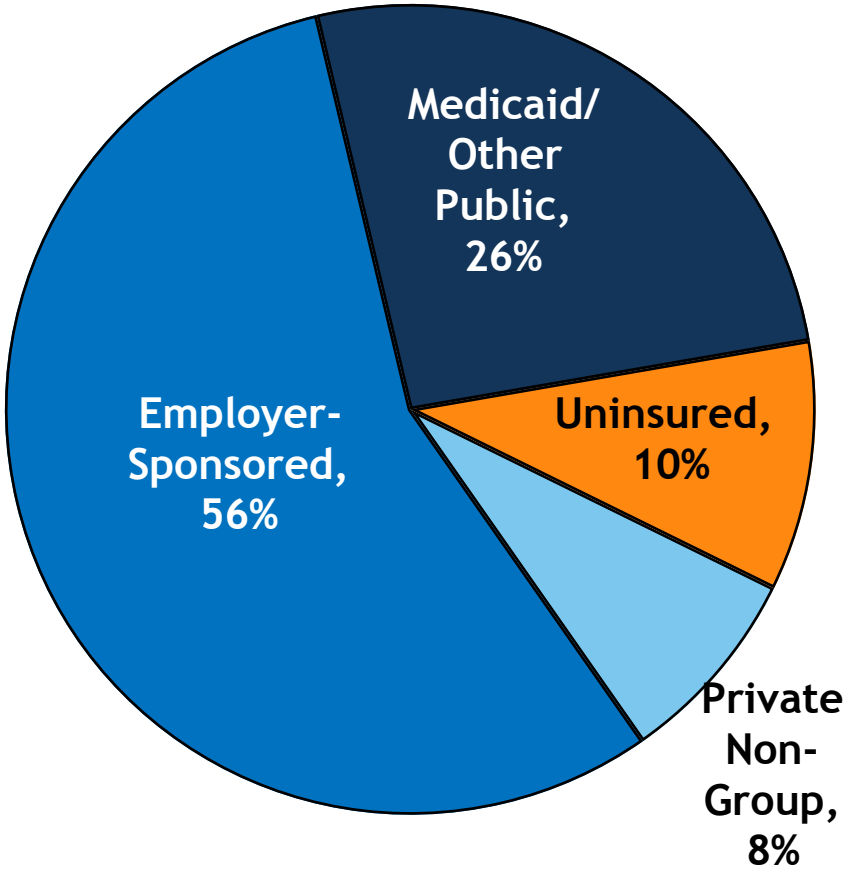
U.S. Health System

- U.S. Health system is a overlapping collection of service delivery providers and payers (Private sector & government)
- It is **primarily an insurance based system** with multiple methods to get coverage or care – Many dual & overlapping coverage
  - Employer
  - Medicare
  - Medicaid
  - Veterans administration
  - Military
  - Private sector charity care
  - Other (injury, disability, etc.)

Health Service & Clinical Providers

- Range of providers include:
  - Private, solo practioner or in a group practice
  - Employed by a larger health entity
  - Government employee in federal, state or local health facility
- Health service providers
  - Private sector hospitals & clinics
  - Government owned hospital & clinics
    - Veterans, Military
    - State, county/city

Breakdown Nonelderly Insurance Coverage 2015



Medicaid and other public coverage includes: CHIP, other state programs, Medicare and military related coverage.
Data may not total 100% due to rounding. SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.

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Private Health Insurance

- Payer can be private, government employer, or the individual / family – Usually a combination of payers
- Individuals pay a monthly charge (Premium) and a range of risk sharing costs such:
  - A co-payment whenever the use a service
  - A deductible amount (coinsurance) that you are responsible for “out of pocket” before the insurance pays

Typical Costs

- Employer
  - The average premium for family coverage is **$1,462 per month** or **$17,545** per year. These amounts are generally split by the employer and employee. On average, employers pay: **$5,179** annually (83 percent of the premium) to cover a single employee.
- Deductible
  - The average annual deductible for individual plans is **$4,358** and the average deductible for family plans is **$7,983**

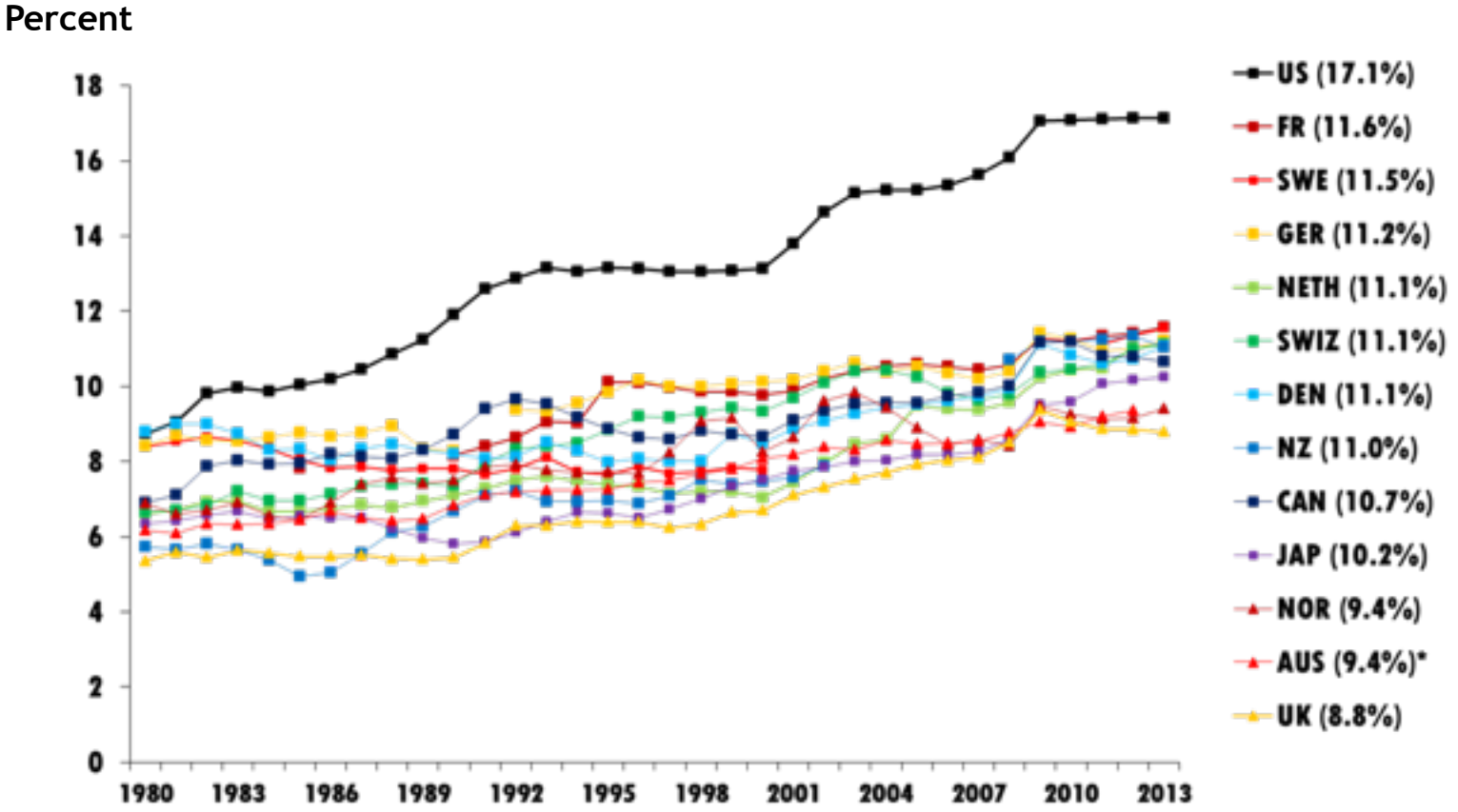
Medicaid Program Insurance

- Federal / state program started in 1965 as welfare program
- Original program covers selected no/low income individuals
- All states participate in this basic program
- States share the costs with feds (50/50 to 90/10)
- Minimal, if any, patient contribution
- Also covers **long term care** for “low income” seniors/disabled

Medicare: Government Run Universal Coverage for Seniors

- Health coverage for people over age 65, disabled & on kidney dialysis
- Has coverage gaps & many people buy a “Medigap Policy”
- Had a coverage gap with high expenditures for prescription drugs (Closed by ACA)
- Paid for through individual payroll tax of 1.45% and a employer contribution of 1.45% (2.9% total)

Health Care Spending As A Percentage of GDP



* 2012

GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers. Source: OECD Health Data 2015. The Commonwealth Fund

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The U.S. Does Not Get The Best Value For Health Spending

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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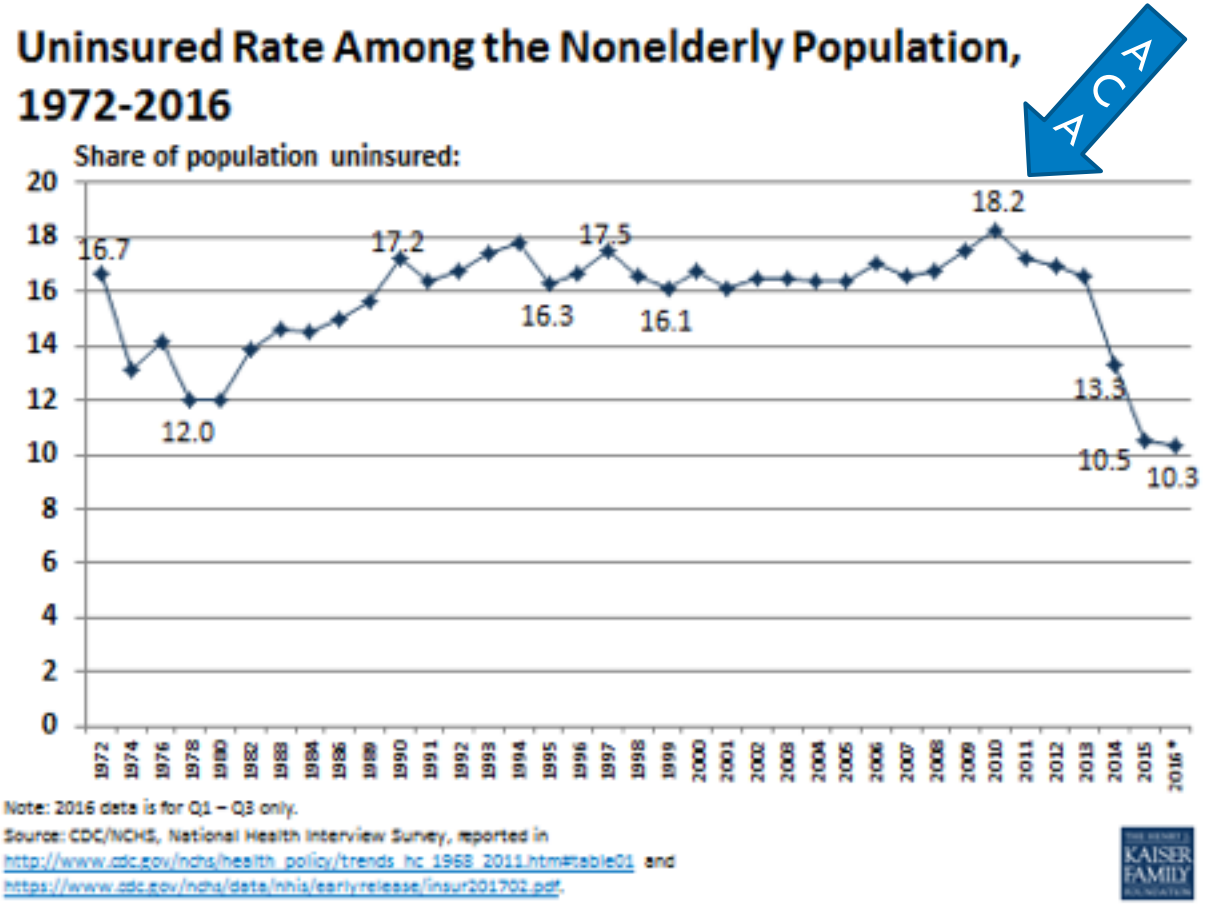
Insurance Coverage Pre ACA



50.3 million Americas without health insurance (Sep 2010)

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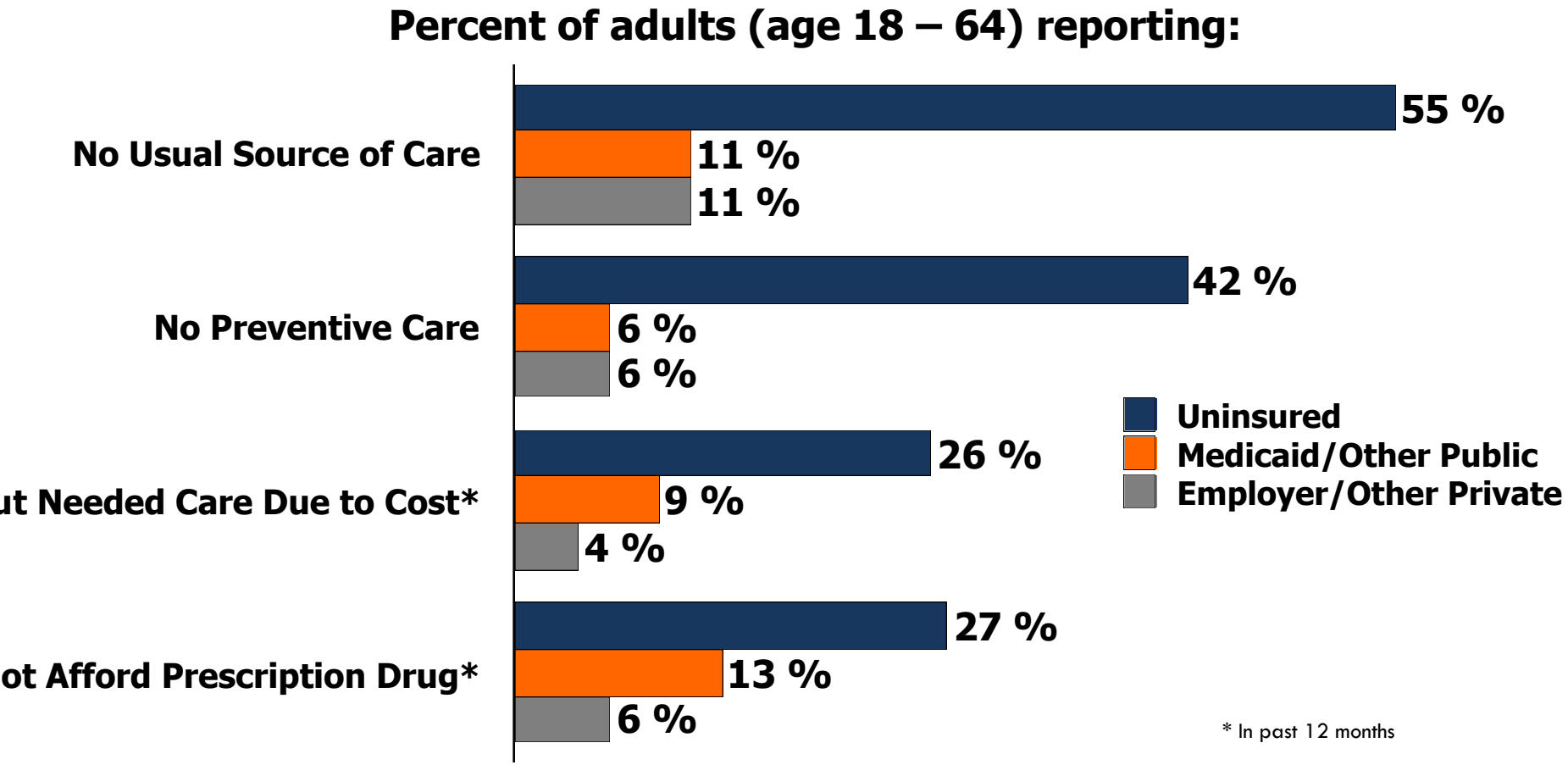
Barriers To Health Care Among Nonelderly Adults, By Insurance Status



Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. SOURCE: KCMU analysis of 2009 NHIS data.

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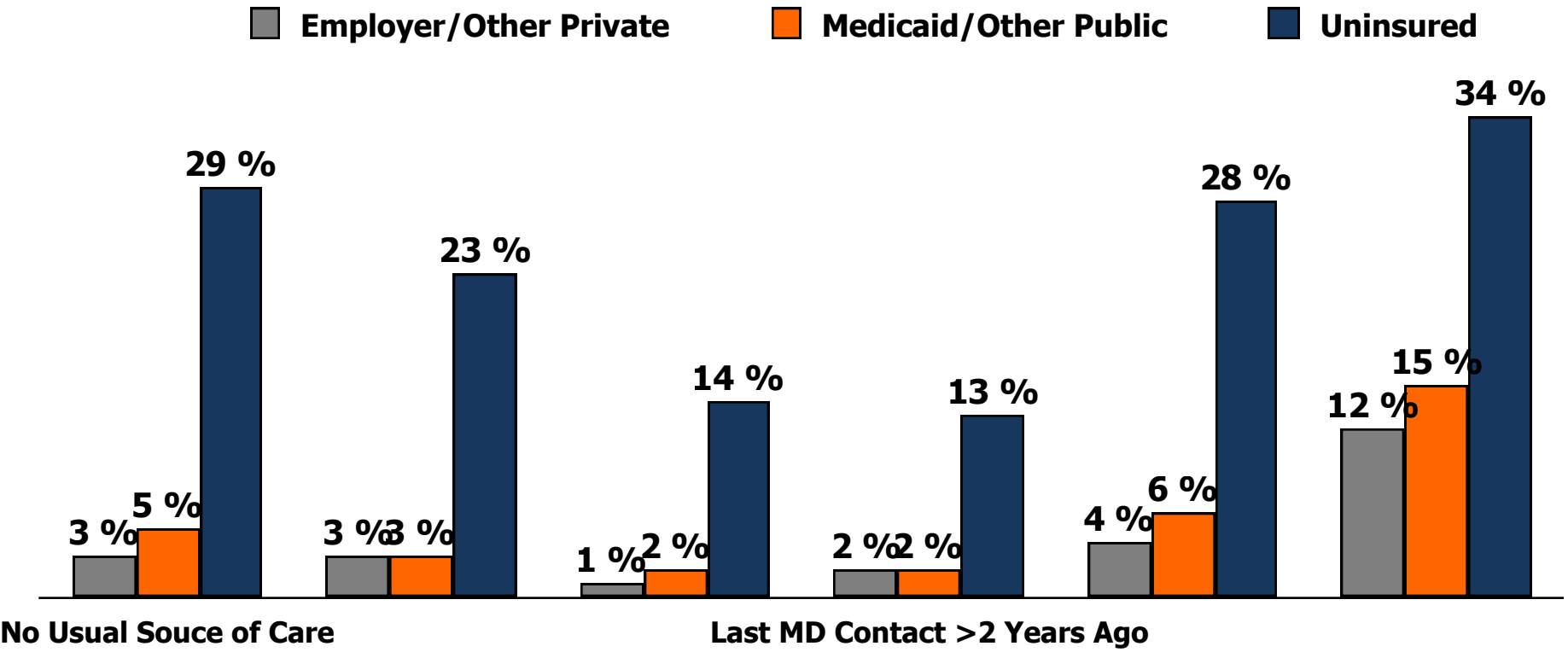
Children's Access to Care, By Health Insurance Status



* Last 12 months

NOTE: Questions about dental care were analyzed for children age 2-17. MD contact includes other health professionals. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of 2009 NHIS data.

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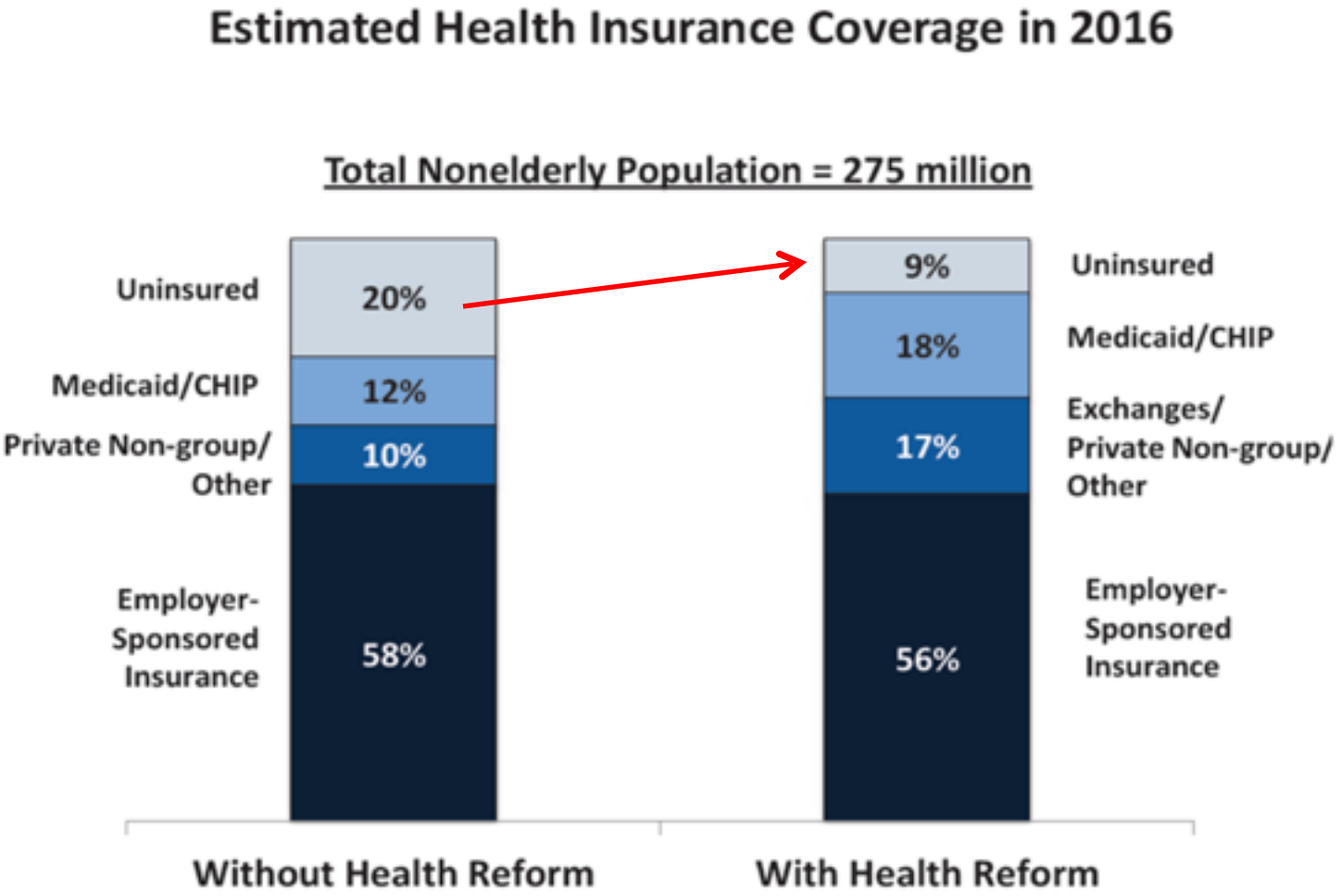
ACA Predicted To Cut Uninsured Rate In Half



NOTE: Estimates based on the assumption that all states will expand Medicaid to individuals with income up to 138% of the federal poverty level.
SOURCE: KFF analysis based on Congressional Budget Office, March 2012. "Updated Estimates for Insurance Coverage Provisions of the Affordable Care Act."

A Clear Need For Health Reform

Too many people lack health coverage & care

System focuses on treatment instead of prevention

Lack of attention to Social determinants of health, health disparities

Inefficient delivery and payment system

U.S. healthcare spending is unsustainable

Low-ranking U.S. health outcomes

The Patient Protection and Affordable Care Act (ACA)

March 23, 2010

ACA had three overall goals

- Improve the individual quality and experience of care
- Improve population health
- Reduce individual costs for care & reduce the cost curve for the system

It is built upon the existing system

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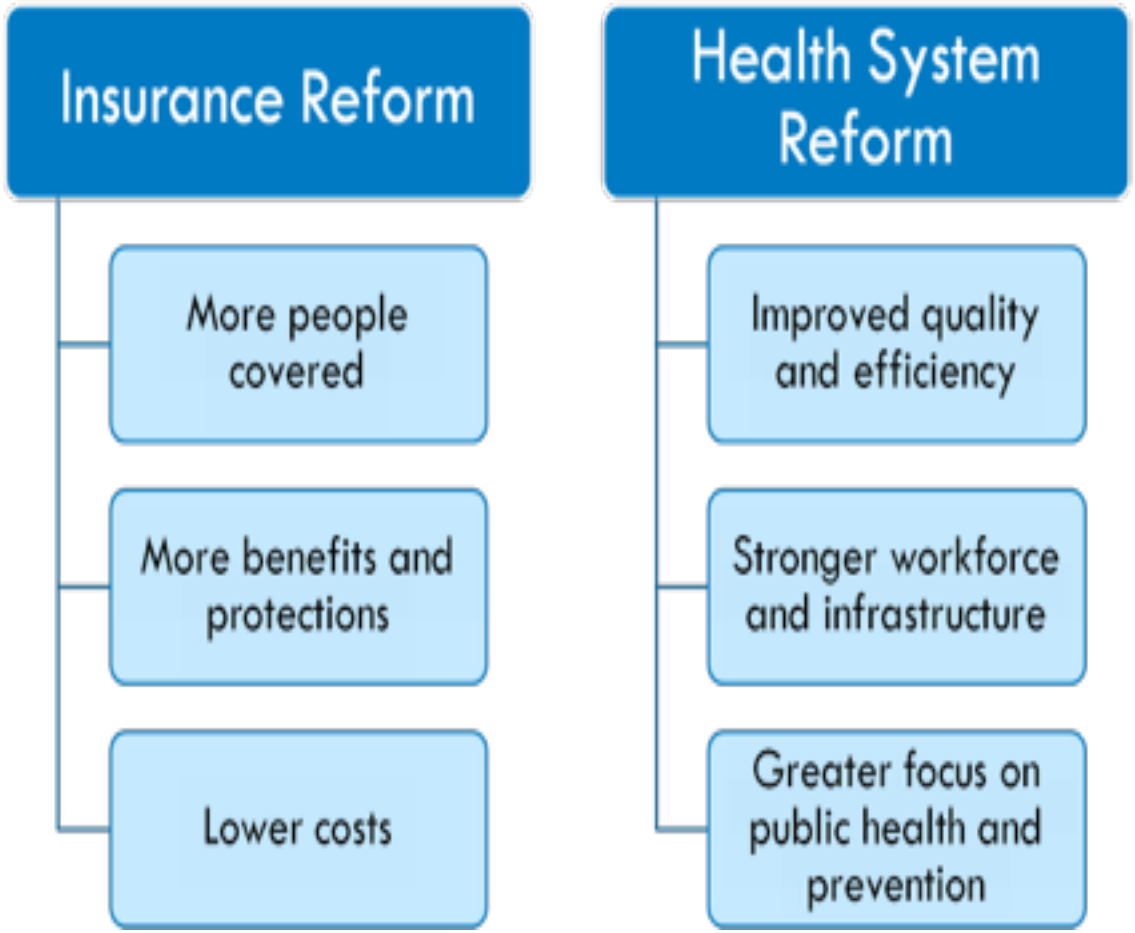
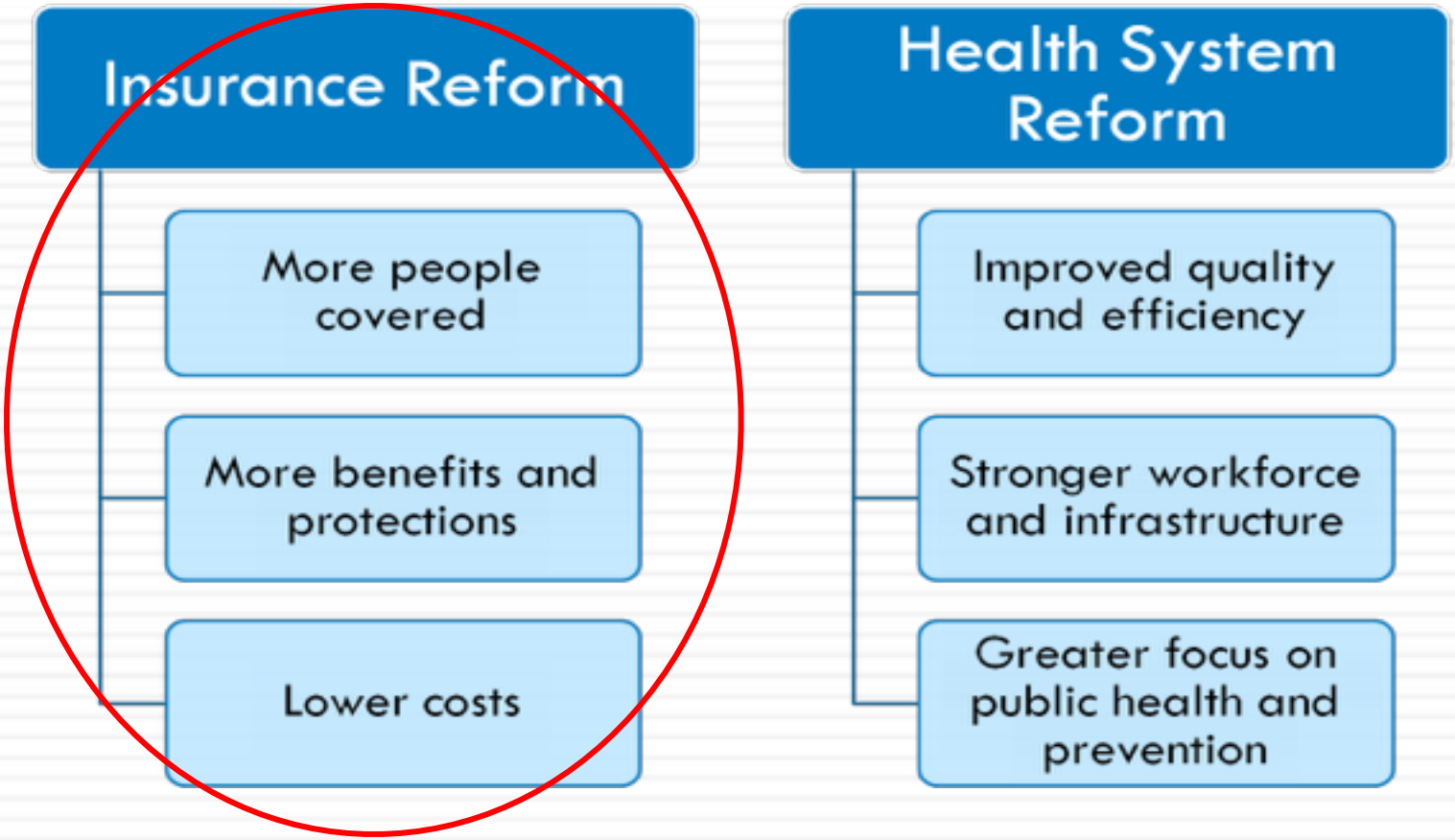
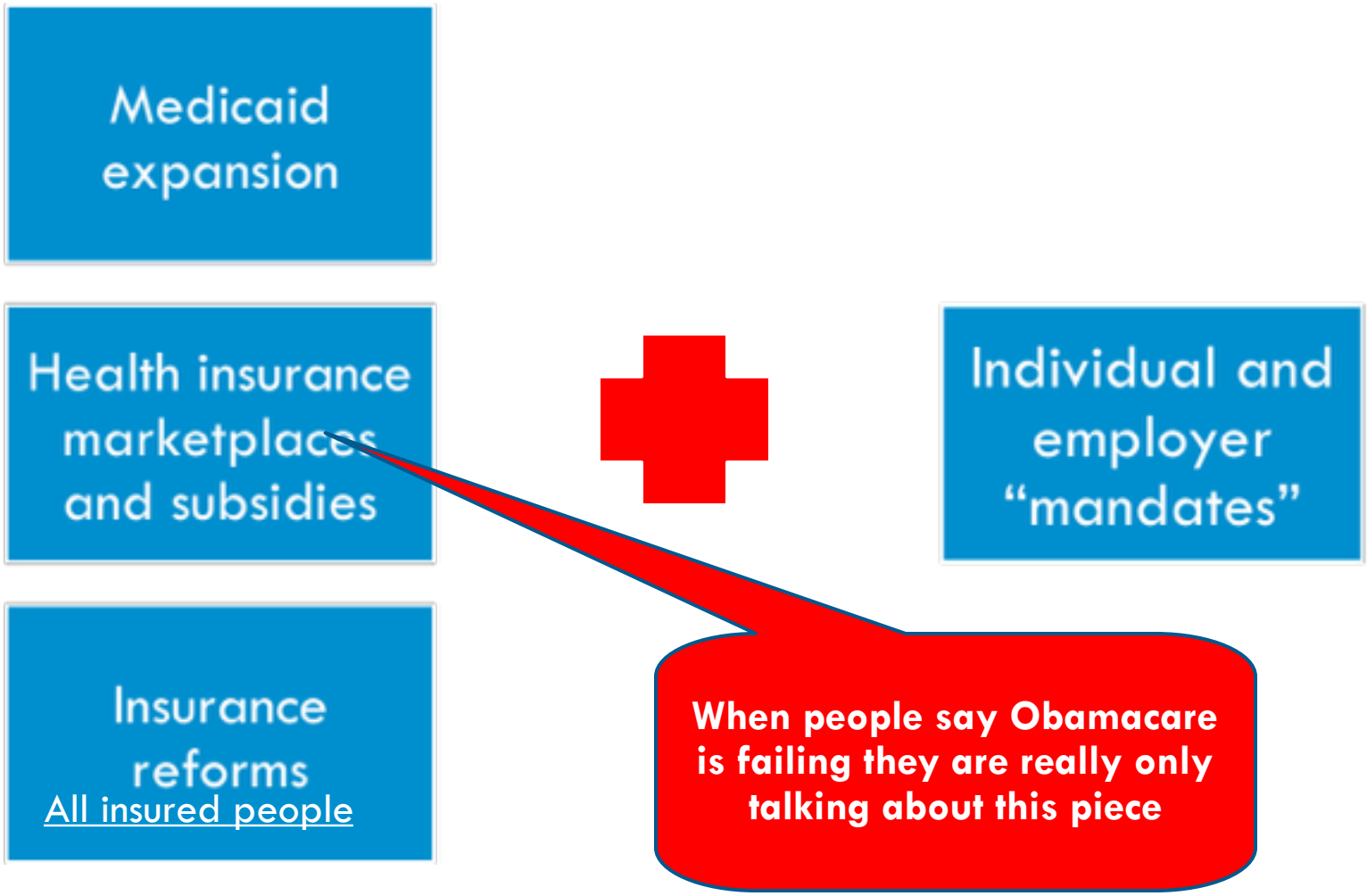
Affordable Care Act Summary



Insurance Reforms



Closing the Coverage Gap: Four Interrelated ACA Approaches



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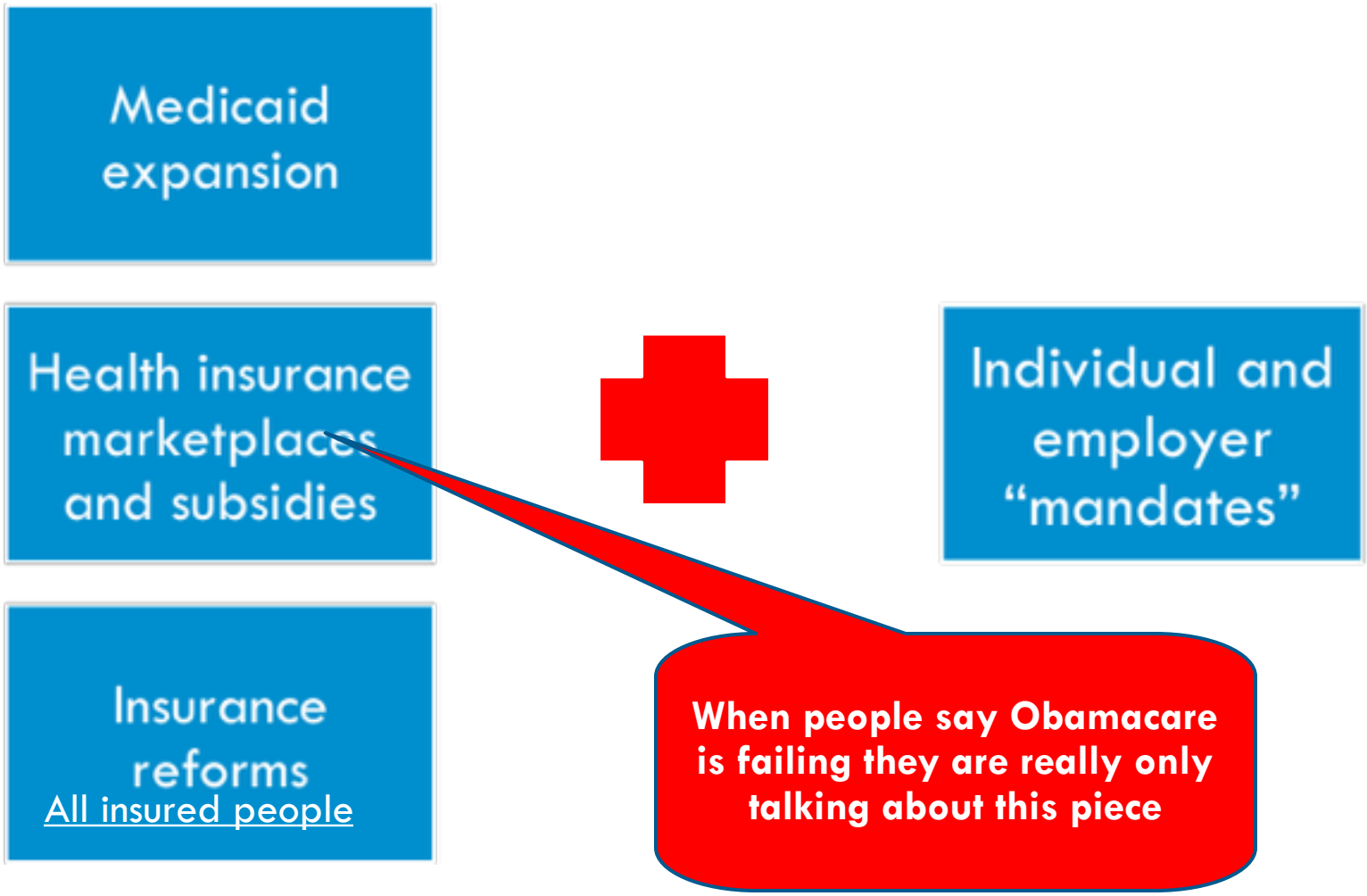
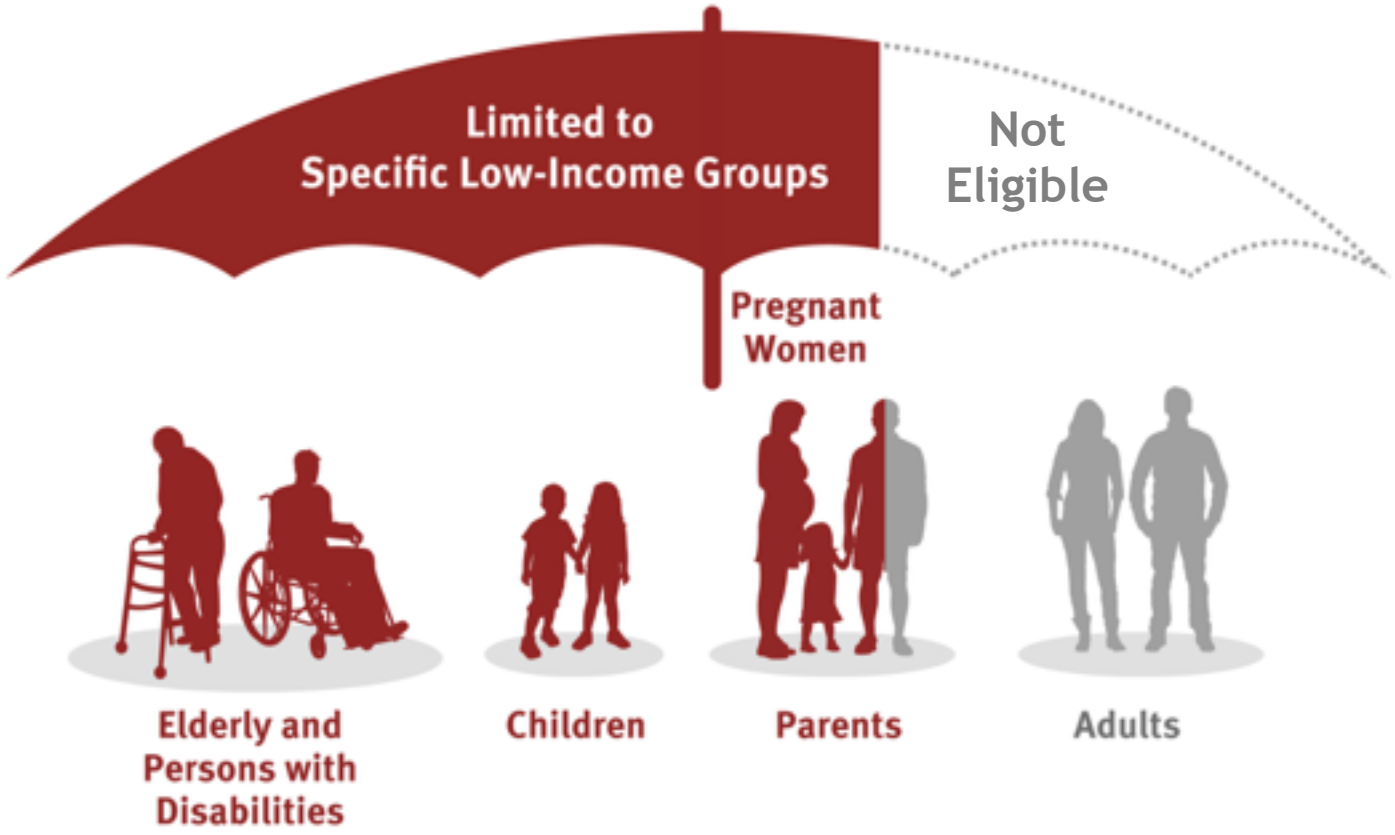
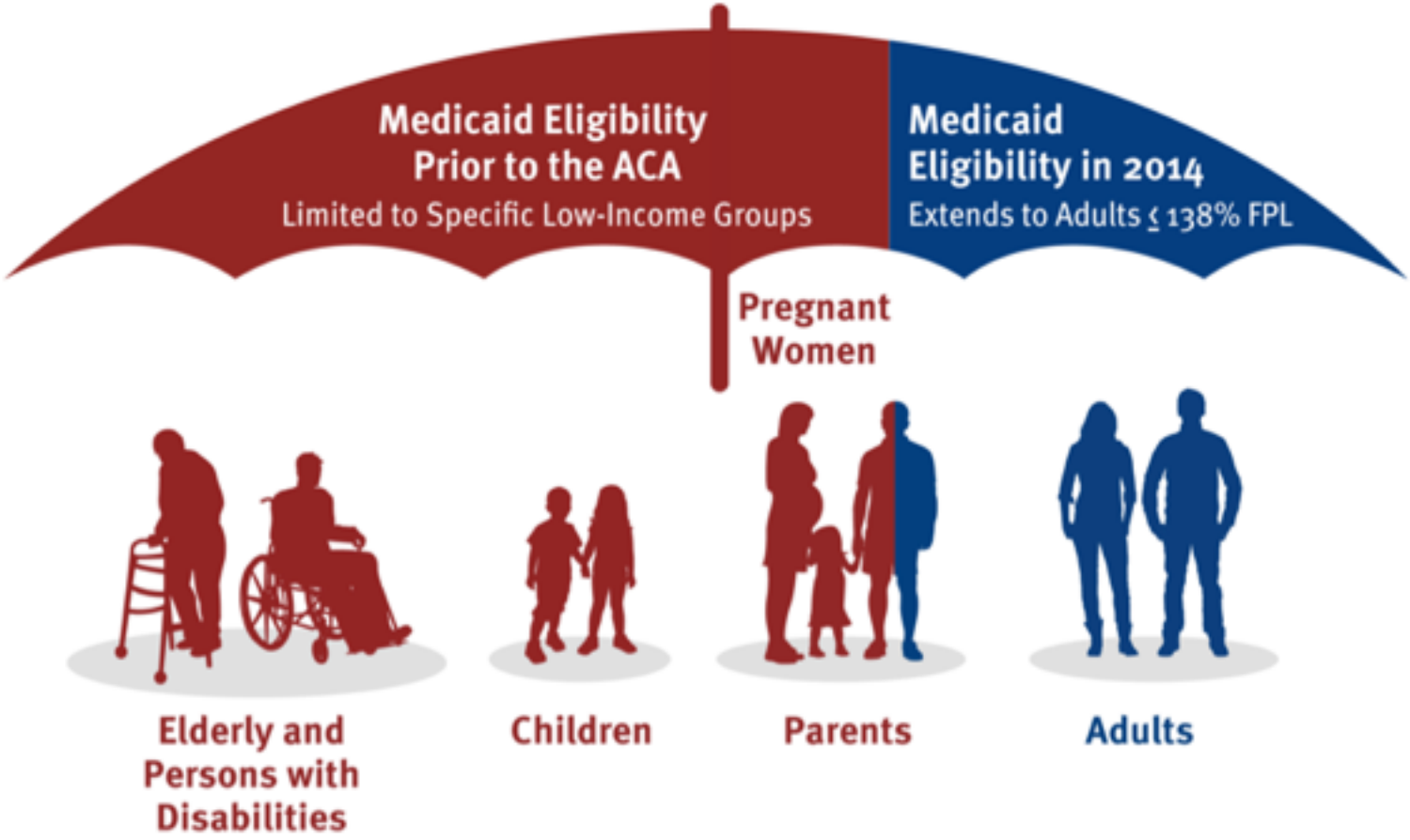


Prior to the ACA, Medicaid Eligibility Limited To Specific Low-Income Groups



As Enacted, The ACA Medicaid Expansion Would Cover Adults Up To 138% FPL In All States, Filling Long-Standing Gaps In Coverage



NOTES: 138% FPL = $16,394 for an individual and $27,821 for a family of three in 2016.

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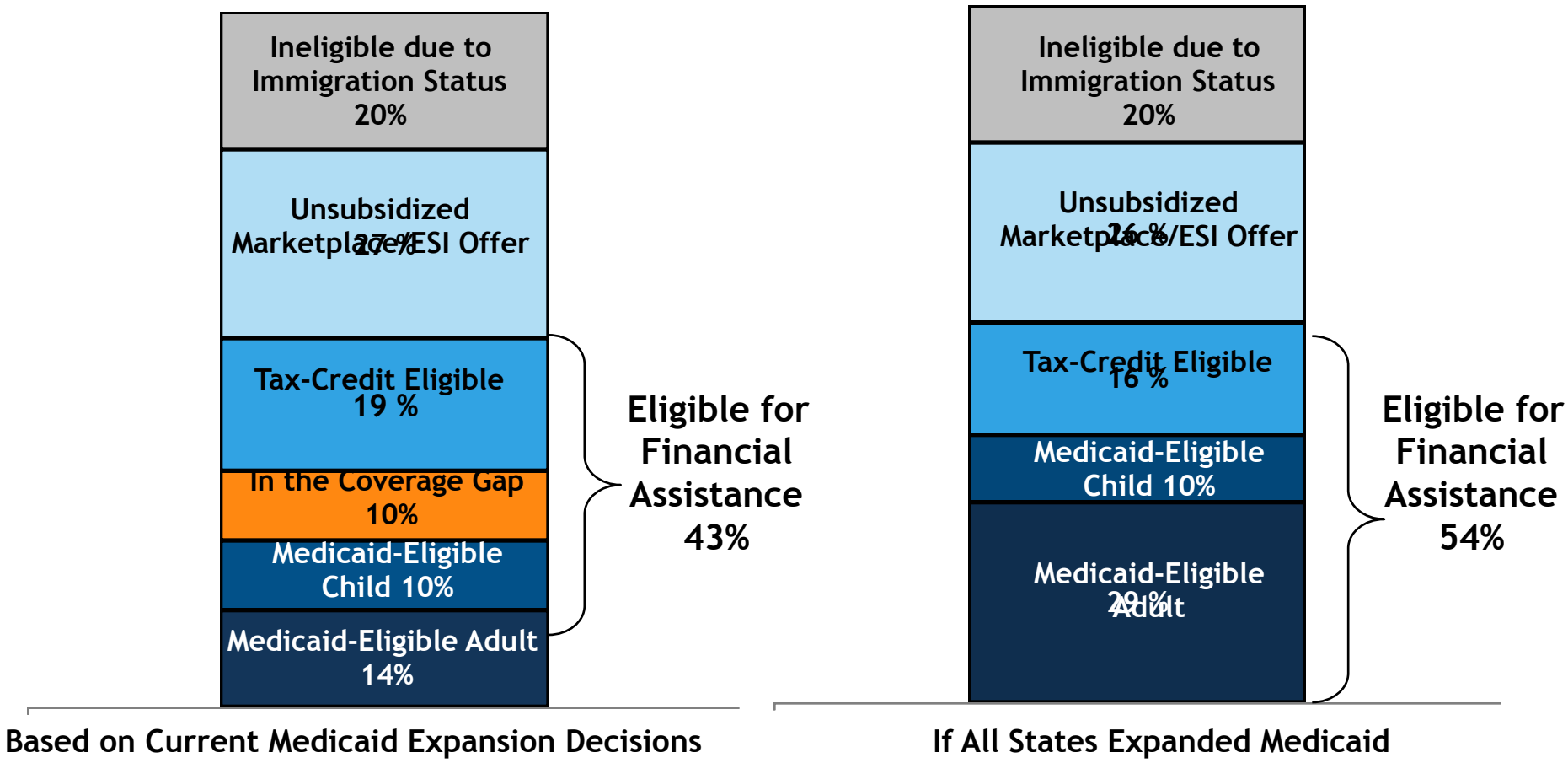
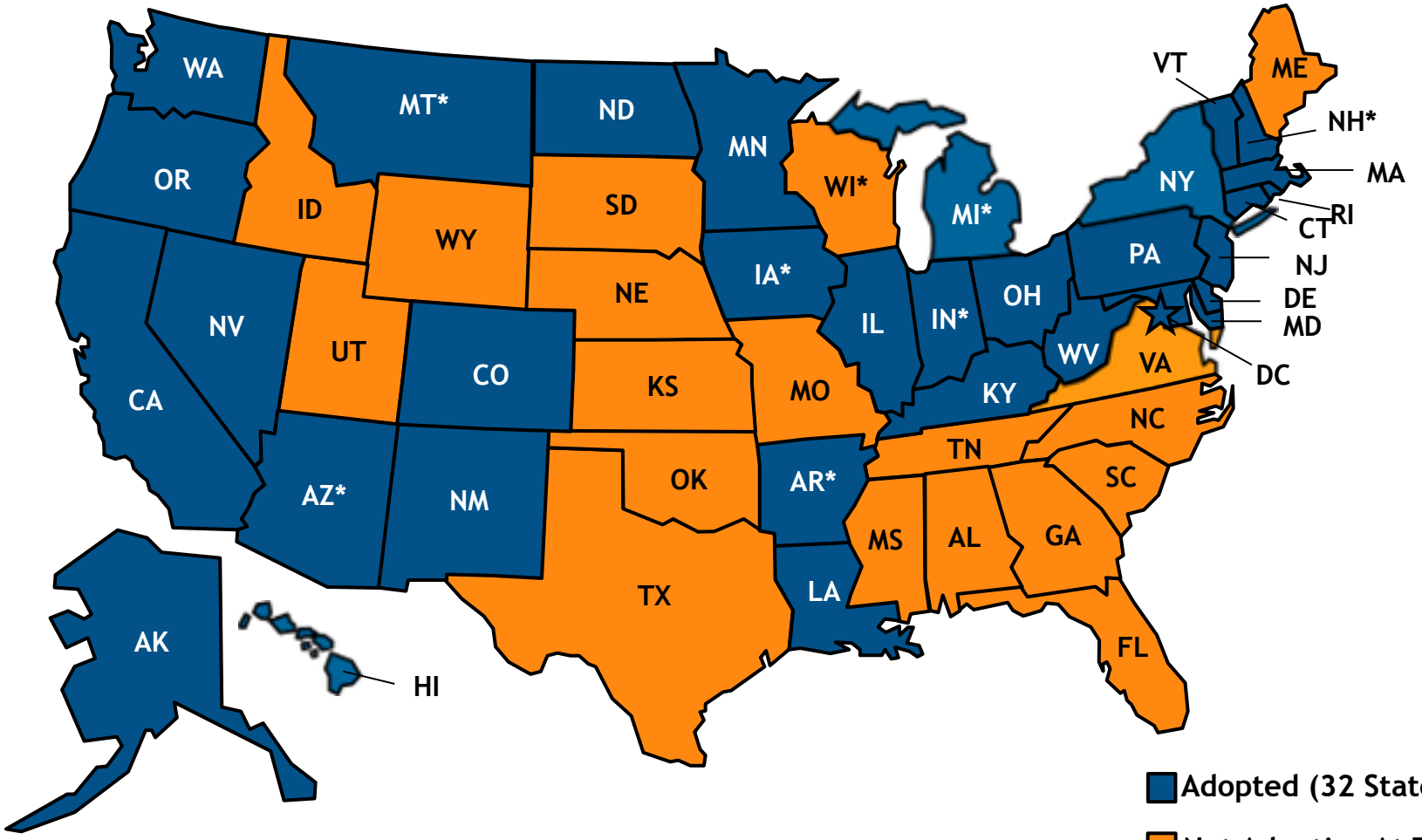
If all states adopted the Medicaid expansion, the coverage gap would be eliminated & 27.2 million of the nonelderly uninsured would be eligible for financial assistance in 2016



Total = 27.2 Million Nonelderly Uninsured (eligible)

NOTES: Numbers may not sum to subtotals or 100% due to rounding. Tax-Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey data.

But, The Supreme Court Effectively Made The Medicaid Expansion A State Option



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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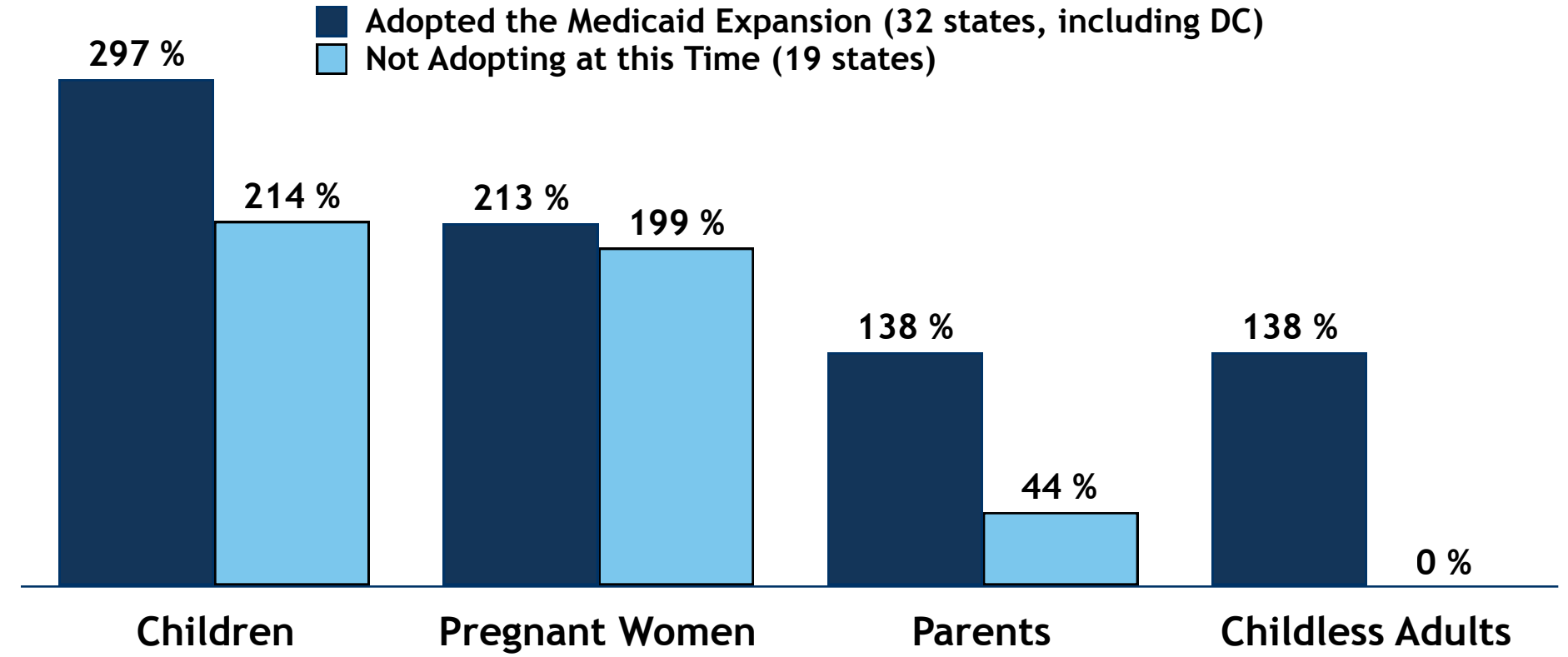
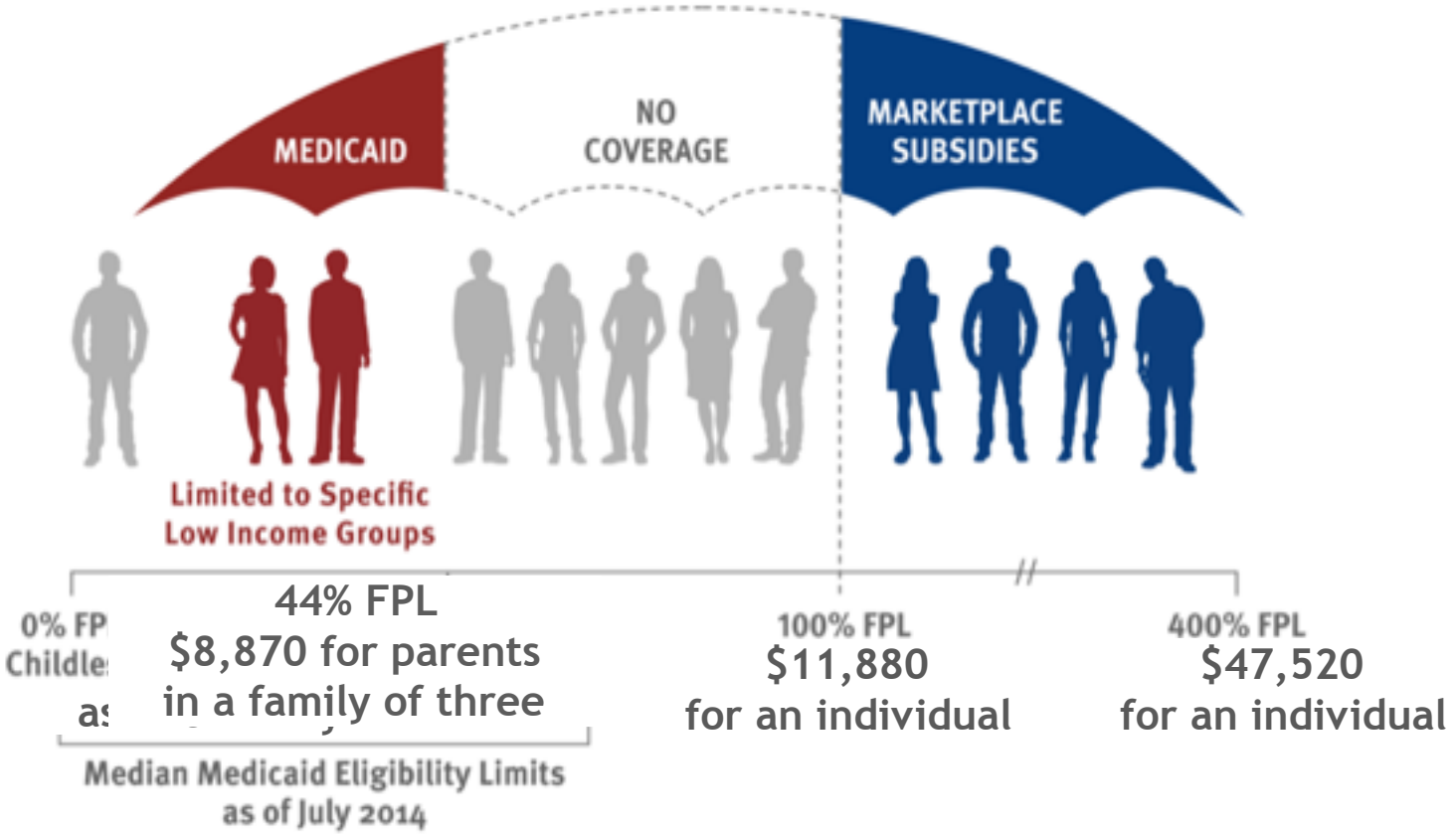
Medicaid Eligibility For Adults Remains Limited In States That Have Not Expanded Medicaid

Median Medicaid/CHIP Income Eligibility Thresholds, January 2016



NOTE: State-reported eligibility levels as of Jan. 1, 2016, updated to reflect Medicaid expansion adoption in Louisiana as of Jan. 12, 2016. Eligibility levels include the standard five percentage point of the federal poverty level (FPL) disregard. As of 2016, the FPL was $20,160 for a family of three and $11,880 for an individual.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016 with data updates based on new state decisions to expand Medicaid.

In states that have not adopted the Medicaid expansion, poor adults fall into a coverage gap, earning too much to qualify for Medicaid but too little for subsidies for Marketplace coverage



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Health Insurance Marketplaces (Exchanges): New Consumer Options

Why they are important

- A new and easier way to shop for health insurance
- "Strength in numbers" – **Restructured individual market**

How they work

- **Three models**: state-run; state-federal partnership; or federally-facilitated
- **Websites for consumers to shop and apply**, plus phone and in-person assistance
- Single streamlined application
- **Affordability credits and subsidies**
- Open enrollment begins Oct. 1 annually; plan year begins Jan. 1

Plans Sold In The Marketplaces

"Qualified Health Plans" (QHPs)

- Private insurance plans
- Must cover "**essential health benefits"**
- Must offer **certain levels of value** ("metal levels")
- Must include "**essential community providers,"** where available, in their networks
- Must comply with ACA reforms

Insurance Reforms: Protecting Access, Controlling Cos

Most insurers CAN'T:

- Deny coverage due to pre-existing conditions
- Rescind coverage over simple paperwork mistakes
- Set lifetime caps on essential coverage
- Charge women more than men (gender rating)

Most insurers MUST:

- Cover "essential health benefits"
- Cover preventive services with no co-pays or deductibles
- Cover young adults on their parents' plan through age 26
- Spend more on services, less on profits (MLR)
- Justify double-digit rate increases (rate review)

No-Cost Clinical Preventive Services

No deductibles or co-payments

Such as:

- Cancer screenings like mammograms and colonoscopies
- Vaccinations such as flu, mumps, and measles
- Blood pressure and cholesterol screenings
- Tobacco cessation counseling and interventions
- Women's preventive health services such as pap smears and birth control*

*Certain religious organizations are have been exempted.

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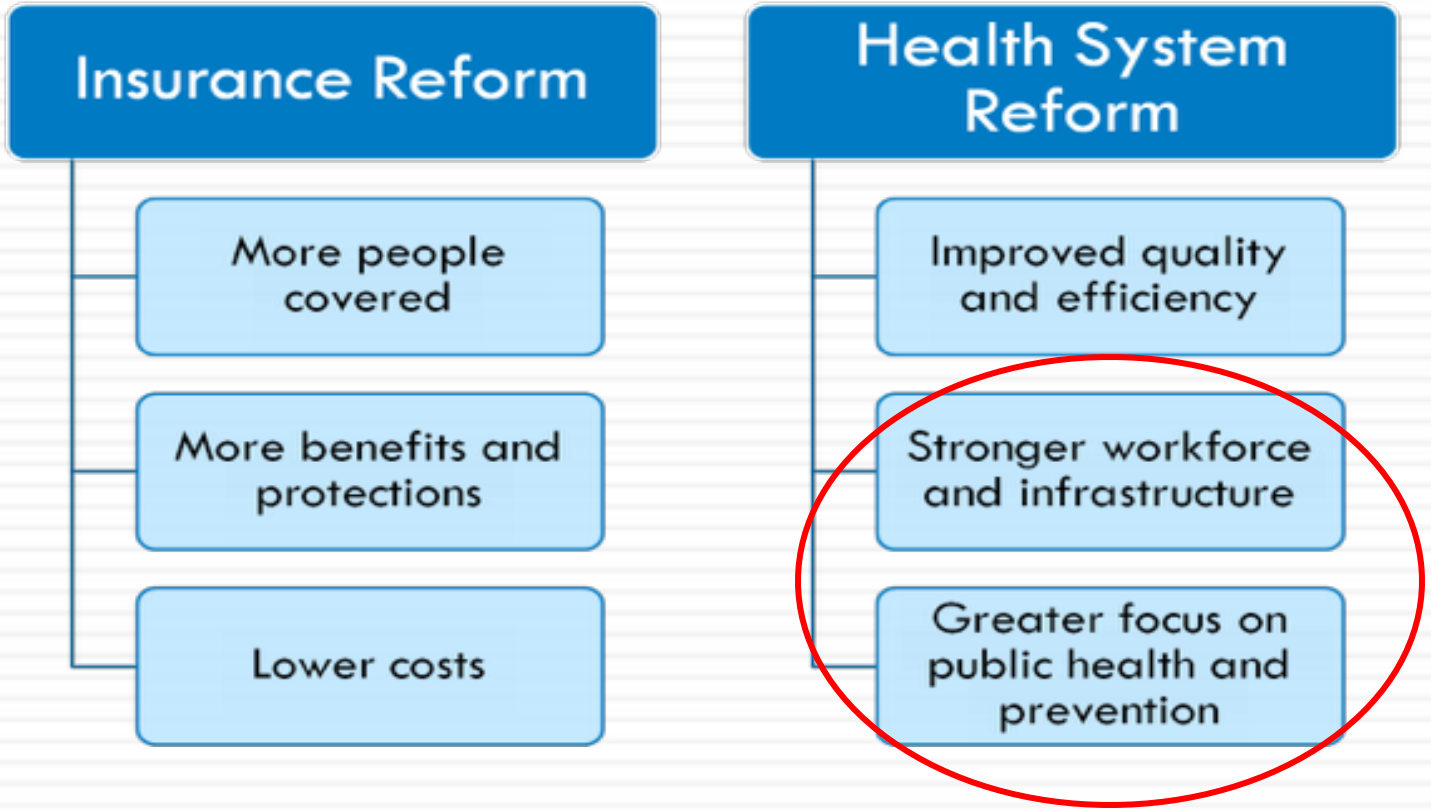
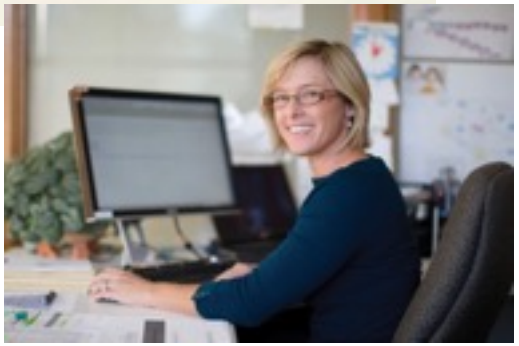
Individual & Employer Mandates To Keep The Markets Balanced

- **Most individuals and families must obtain minimum essential coverage or pay a penalty**
  - Acceptable coverage includes employer-based, plans in the marketplaces, public insurance, and more
  - Numerous exemptions such as religious objections, financial hardship, undocumented immigrants
- **Large employers (50+) must offer minimum essential coverage to full-time employees, or pay penalties**
  - Penalties only apply if employees instead get coverage and subsidies in marketplaces

Health system reforms: public health, workforce and infrastructure provisions



Prevention and public health; workforce & infrastructure provisions

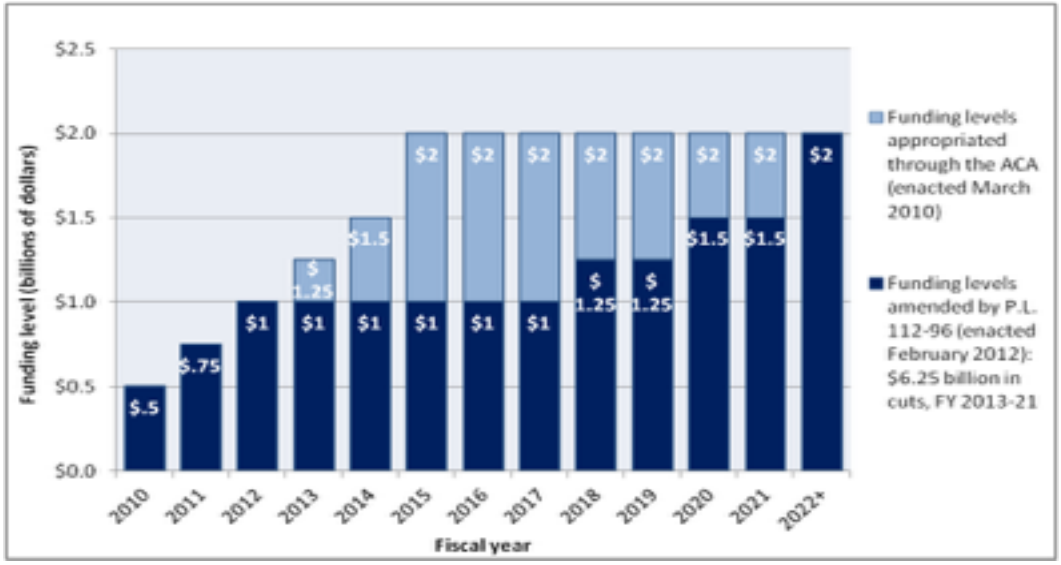


- Prevention and Public Health Fund
- **National Prevention Council & Strategy**
- Community health needs assessments
- Community and school-based health center funding
- Public health and primary care workforce development
- Health equity promotion
- Public health research
- Public education campaigns
- Menu labeling

Prevention and Public Health Fund

- A much needed investment in prevention
- The U.S.'s first *mandatory* funding for public health
- Meant to supplement, not supplant, existing funding
- Public health system still underfunded; but a start

Prevention Fund Amounts Per Year



- Original funding: $15B over fiscal years (FYs)10-19, then $2B per year
- P.L. 112-96 (Feb 2012): cut $6.25B over 9 years (FY13-21)
- Additional taps for physician payments & research at NIH
- ACA repeal will cut 12% of CDC budget (~$900 million)

Chart source: APHA: The Prevention and Public Health Fund (2012). Data sources: Affordable Care Act; P.L. 112-96.

The Prevention and Public Health Fund: Four Major Funding Goals

Clinical prevention	Community prevention	Workforce and infrastructure	Research and tracking
• Enhance awareness of ACA prevention services and benefits • Immunization programs • Integrating primary and behavioral health	• **Community Transformation Grants** • Comprehensive Chronic Disease Prevention Grants • Other efforts (e.g. CDC's "Tips from Former Smokers" campaign)	• **National Public Health Improvement Initiative** • Lab capacity grants • Workforce training grants	• **National Prevention Council & Strategy** • Environmental Public Health Tracking System • Prevention research centers

The Fund also supports more programs and initiatives in each category.

Community Health Needs Assessments (CHNAs)

- Tax-exempt hospitals must conduct CHNAs and implement strategies to address community needs
  - A revision to existing community benefit requirements
  - Assessments done every 3 years

- CHNAs must take into account input from "persons who represent the broad interests of the community served by the hospital facility, **including those with special knowledge of or expertise in public health."**

Other Key Public Health Provisions

- **Public education campaigns**
  - Lifestyle choices, chronic diseases (campaigns active)
  - Menu labeling (coming soon?)
  - Oral health (campaign not yet active)
- **Health equity promotion**
  - REACH (Disparities) funding
  - Data collection & reporting
  - Research, training, workforce (funded?)
- **Workplace wellness programs**
  - Incentives; implementation grants

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Workforce and Systems Funding

- **PH workforce training:** Avg $30M/yr over 2 years
- **Community health centers:** $11B over 5/yr
- **School-based health centers:** $50M/yr over 2 years
- **PH services and systems research:** $20M, 1 year
- But many **unfunded provisions**:
  - PH workforce loan repayment program
  - Community health workforce grants
  - National Health Workforce Commission

Original intent was to fund these through regular appropriation process

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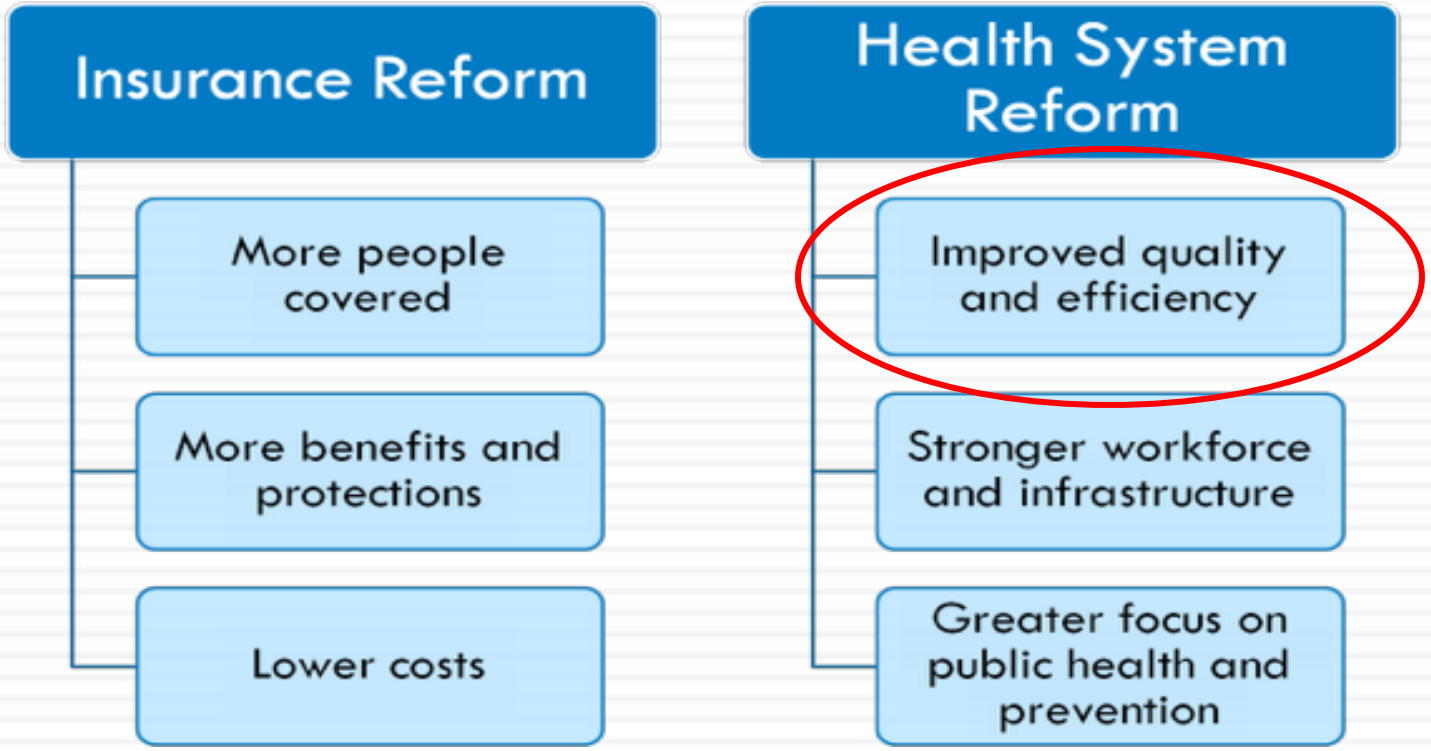
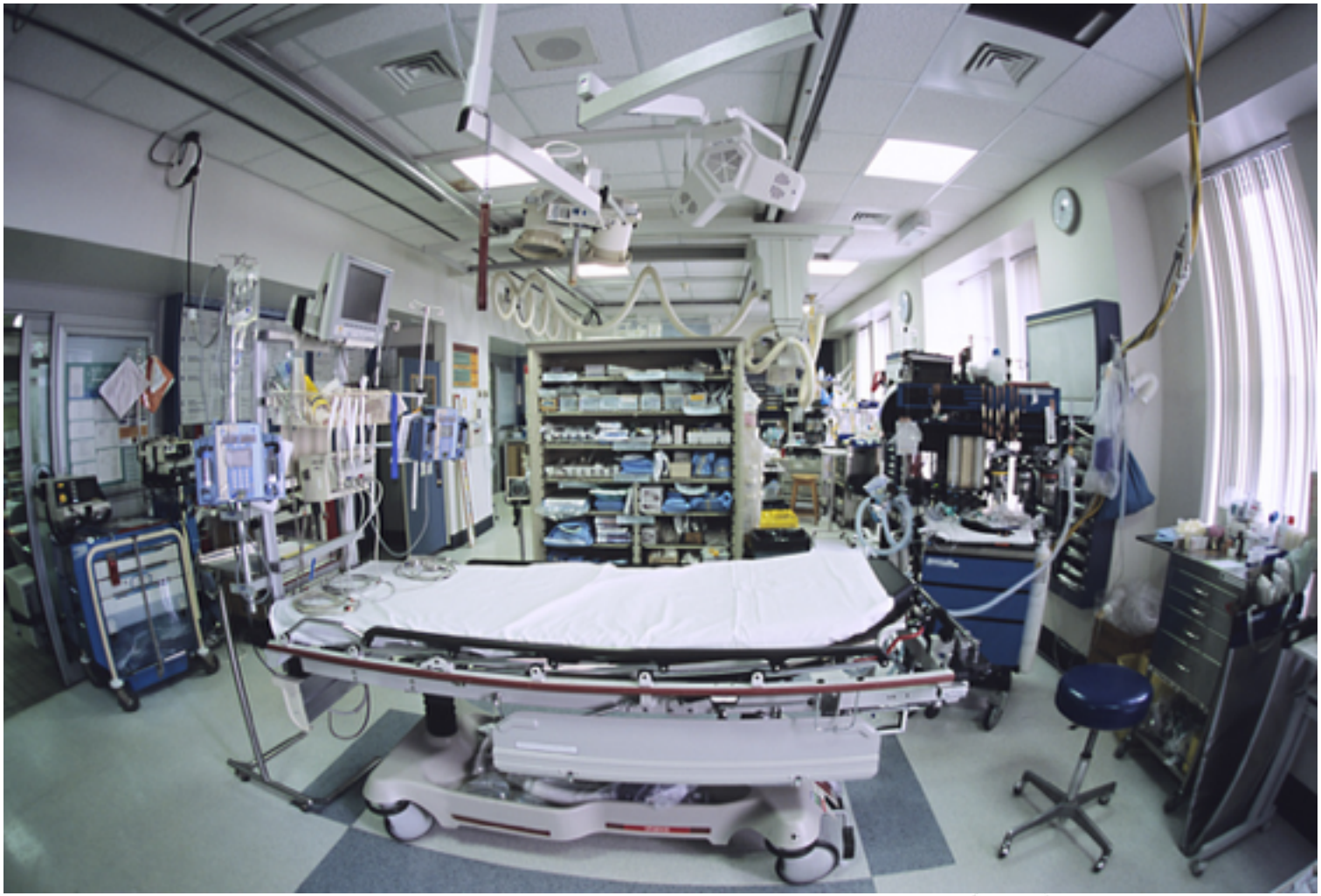
Health system reform: delivery, payment and quality provisions



Too Much Of This



Not Enough Of This

Almost None Of This

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Accountable Care Organizations

- Networks of providers that coordinate care for patient populations
  - Goals: control costs, increase quality, improve population health
  - Bonuses for hitting quality and cost targets (Penalties also)
- Now more than 400 ACOs in the U.S.
  - Medicare Shared Savings Program
  - Medicare Pioneer Program
  - Private insurer ACO contracts
  - Medicaid initiatives

Patient Centered Medical Homes

Primary care practices (PCPs) that receive monthly fees to provide “whole person” enhanced care for patients (primarily those with chronic illnesses).

Multiple models

- Multi-payer Advanced Primary Care Practice Demo
- FQHC Advanced Primary Care Practice Demo
- HRSA Patient-Centered Medical/Health Home Initiative
- Medicaid Health Home State Plan Option
- Comprehensive Primary Care Initiative

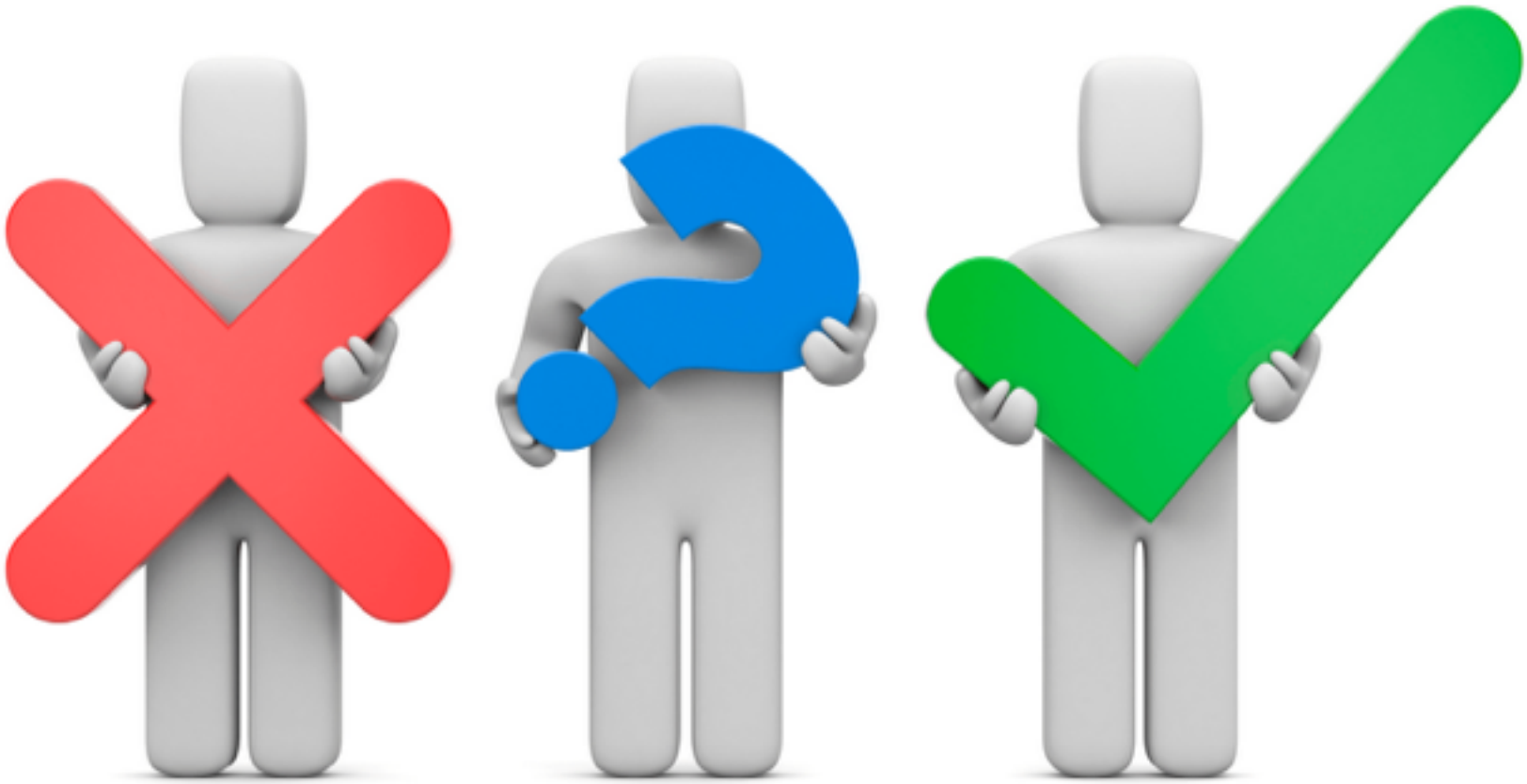
Other Delivery And Payment Reforms

- **Community-based Care Transitions Program:** hospital and CBO coordination to reduce readmissions
- **State Innovation Models Awards:** to design or test new delivery and payment models
- **Bundled Payments for Care Improvement**: one bundled Medicare payment to multiple providers, to encourage coordination
- **Pay for performance programs like VBP:** Medicare payments tied to performance on outcome measures
- **Health IT:** Electronic health records, health information exchanges

Separate Efforts To Improve Care Outside Of ACA

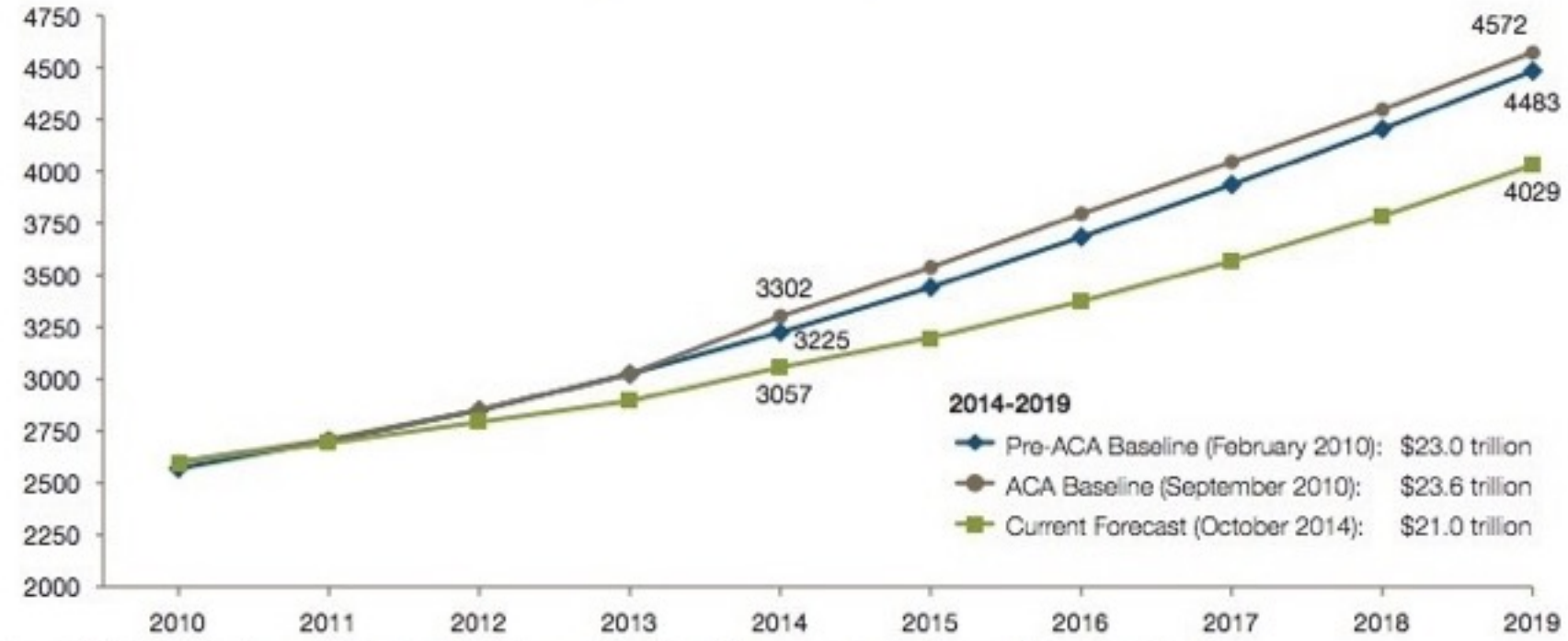
- Veterans health care system - Largest integrated health care system in the U.S.
  - Can go out of the system for care
- Military care - Through the Department of Defense health care system
  - Active duty
  - Eligible families – TriCare System

ACA Results



2.6 Trillion Less Expensive Than Expected

Figure 1. National Health Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.

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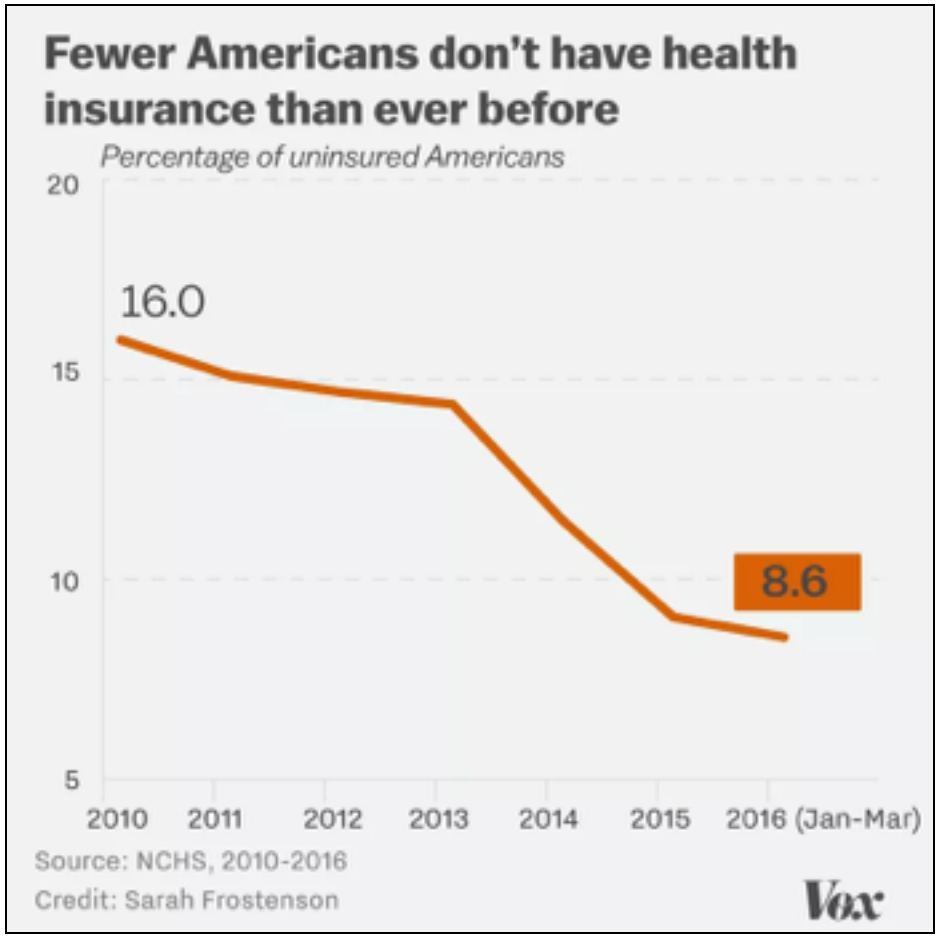
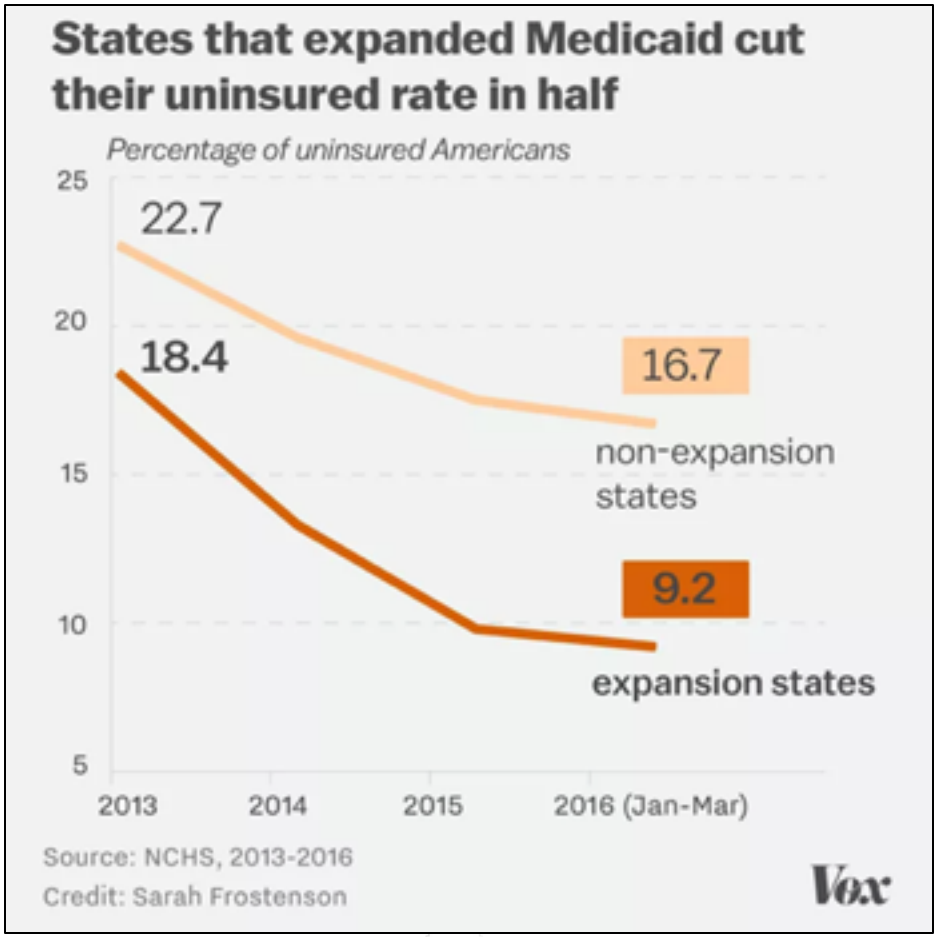
Marked Reductions In Uninsured





Improved Clinical Outcomes

- Mortality down in covered states
- Medicare 30 day hospital readmission rate down
- Ambulatory sensitive services & visits increased
- Preventive service use increased
- Economic wellbeing of insured improved

Great Progress In Moving Upstream To Improve Community Health

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ACA Inspired & Funded Programs Successful At Community Health Improvement

- Community Transformation grants
- CDC Healthy Communities Program (CPPW)
- RWJF Culture of Health Prizes
- Michele Obama's Let's Move

Where Do We Go From Here

Massive Uncertainty In Health

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New Challenges To Public Health

- Pledged to repeal & replace ACA
- Attacks on women's health
- Health regulatory rollbacks
- Rollback on gains on social factors that impact health
- Community health efforts at risk
- Climate change denial
- Massive budget cuts proposed

The ACA Critics Perspective

- Belief that this is an individual responsibility & limited support for low income populations
- Policies sold through some health exchanges are more expensive & have less provider participation than hoped
  - They are stable in most states
  - States that did not expand Medicaid & have not worked to make them effective are having more problems
  - Critics are overstating the problem BUT it does need to be fixed

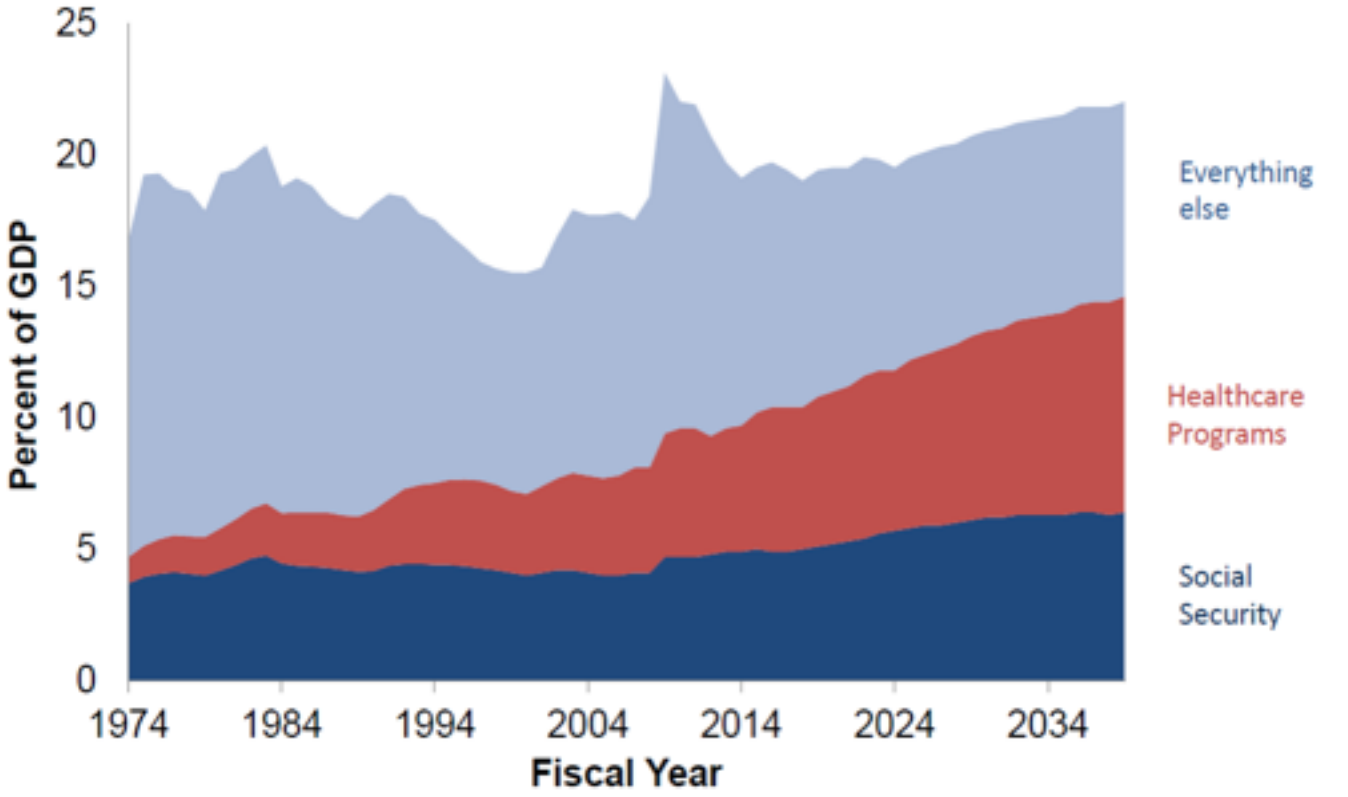
Replacement Policy Ideas Under Discussion In AHCA*

- Health savings accounts
- Tax credits
- Buying across state lines
- State high risk pools
- Lability reform
- Block grant Medicaid or per capita caps
- Limiting preexisting conditions
- Limiting essential benefits
- Small business and inter-state pools
- Hospital uninsured funding unclear

*American Health Care Act

APHA

Healthcare and Federal Budget

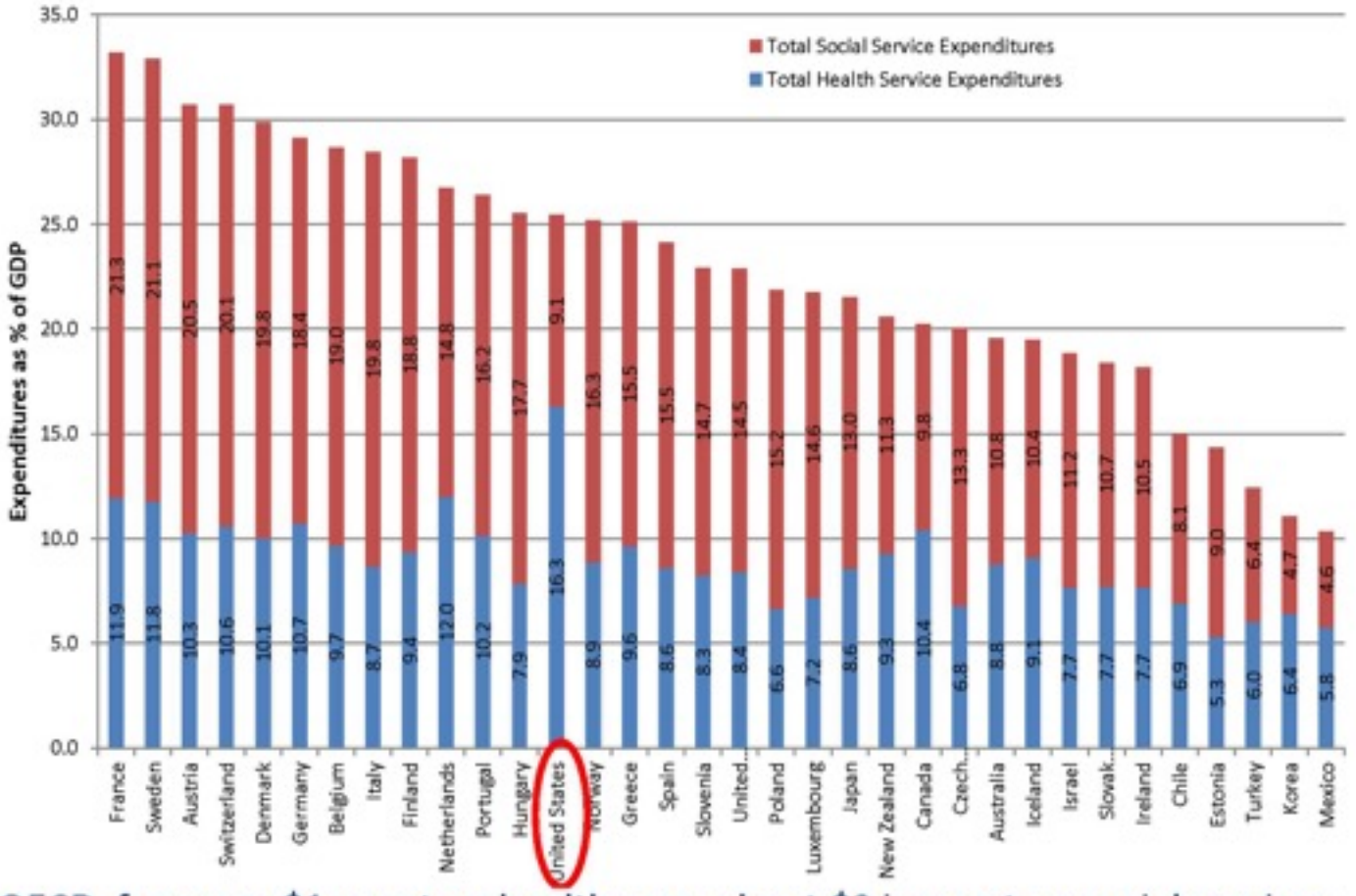


Source: McClellan and Saunders, 2016, based on Congressional Budget Office, 2016 Long-Term Budget Outlook.

Can we afford it?

Spending On Social Services v. Health

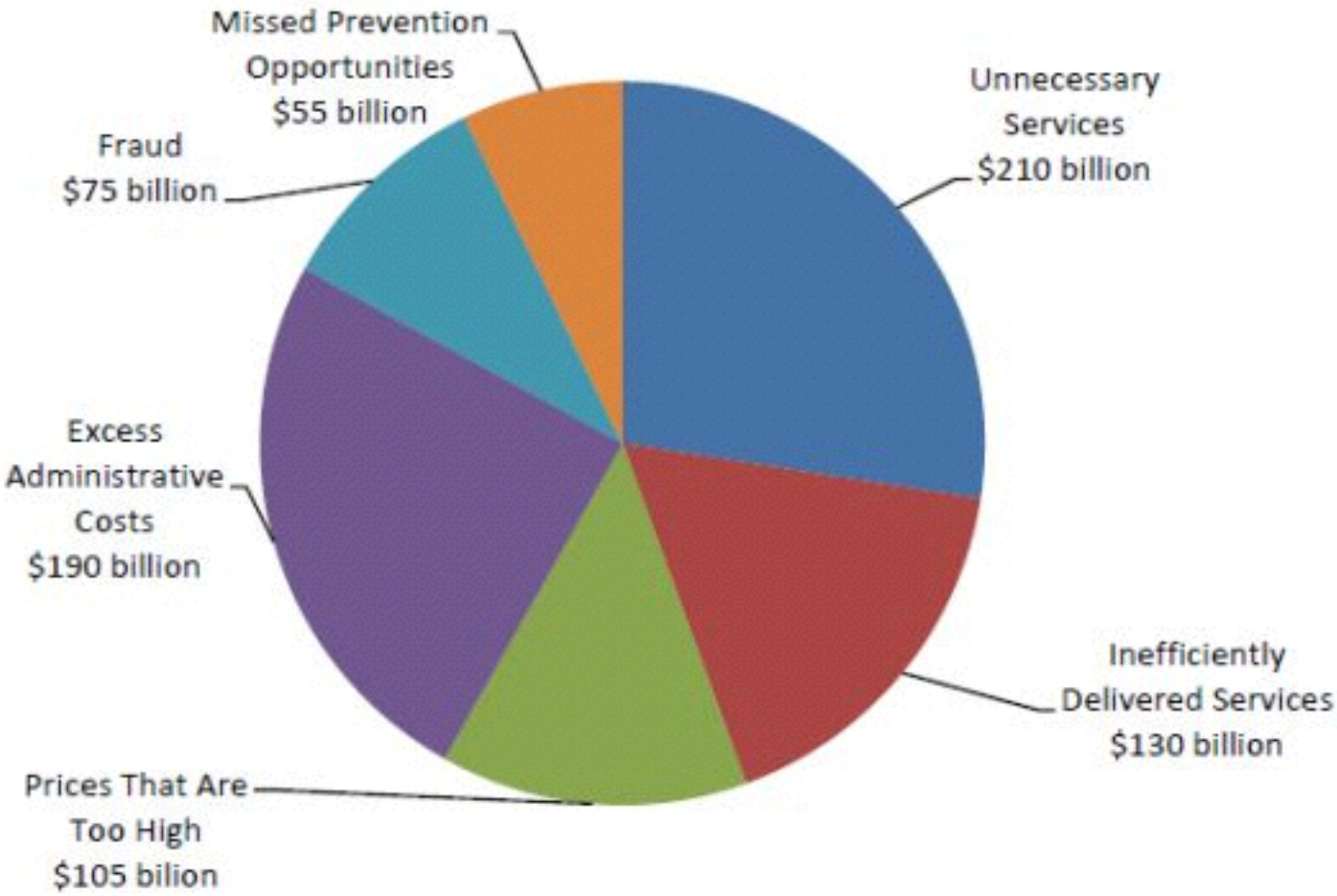
Bradley & Taylor, 2013



In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services

Excess Costs & Care



Kliff S. We spend $750 billion on unnecessary health care. Two charts explain why. Washington Post. September 7, 2012. https://www.washingtonpost.com/news/wonk/wp/2012/09/07/wespend-750-billion-on-unnecessary-health-care-two-charts-explain-why/.

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Inefficient Disease Prevention, Management & Treatment

- ~50% of US adults had 1+ chronic health conditions; ~25% had 2+ chronic health conditions (CDC, 2012)
- 86% of health care spending was for individuals with 1+ chronic conditions (CDC, 2010)
- Mental disorders often overlooked and poorly managed
  - Each year, ~1 in 5 adults experiences a mental disorder (NIMH, 2015)
  - Serious mental illness costs the US $193B in lost earnings/year (Insel, 2008)

Can We Afford It?
The Short Answer Is Yes

- Only industrialized nation without universal health care
- We already pay for it but inefficiently
- Economic value to society rarely accounted for
  - Increase in jobs
  - Less people going into bankruptcy from health care costs
- Our core responsibility is to our peoples health, safety and overall wellbeing

Will The ACA Survive – Yes!!!

- Growing popularity
- It is full of Republican ideas & therefore the opposition has little constructive & new policy ideas to add
- There are reasonable fixes to the exchanges if they can get political consensus to fix them
- All proposals will reduce coverage & increase costs

There was a fundamental values shift in the U.S. Health Care is now viewed as a human right

Our Strategic Direction

Central Challenge:
Create the **Healthiest Nation**
in **One Generation**

OUR MISSION
For what purpose does APHA exist?

- Improve the health of the public and achieve equity in health status

OUR UNIQUE VALUE
What unique role does APHA play in meeting this mission?

- Community of public health professionals and collective voice advocating for the public's health
- History and broad constituency give us unique perspective

OUR GUIDING PRIORITIES
What must be accomplished for APHA to achieve its mission?

- Building public health infrastructure and capacity
- Creating health equity
- Ensuring the right to health and health care

APHA
AMERICAN PUBLIC HEALTH ASSOCIATION

APHA National Policy Agenda

- Defend the Affordable Care Act & expand health insurance coverage
- Build Public Health 3.0
- Address climate change & environmental needs
- Stop regulatory rollbacks
- Protect women's health / Access to reproductive health services
- Address the next new public health crisis of the day
- Enhance our health equity work
- Support sound policy making through evidence & science

APHA

Questions

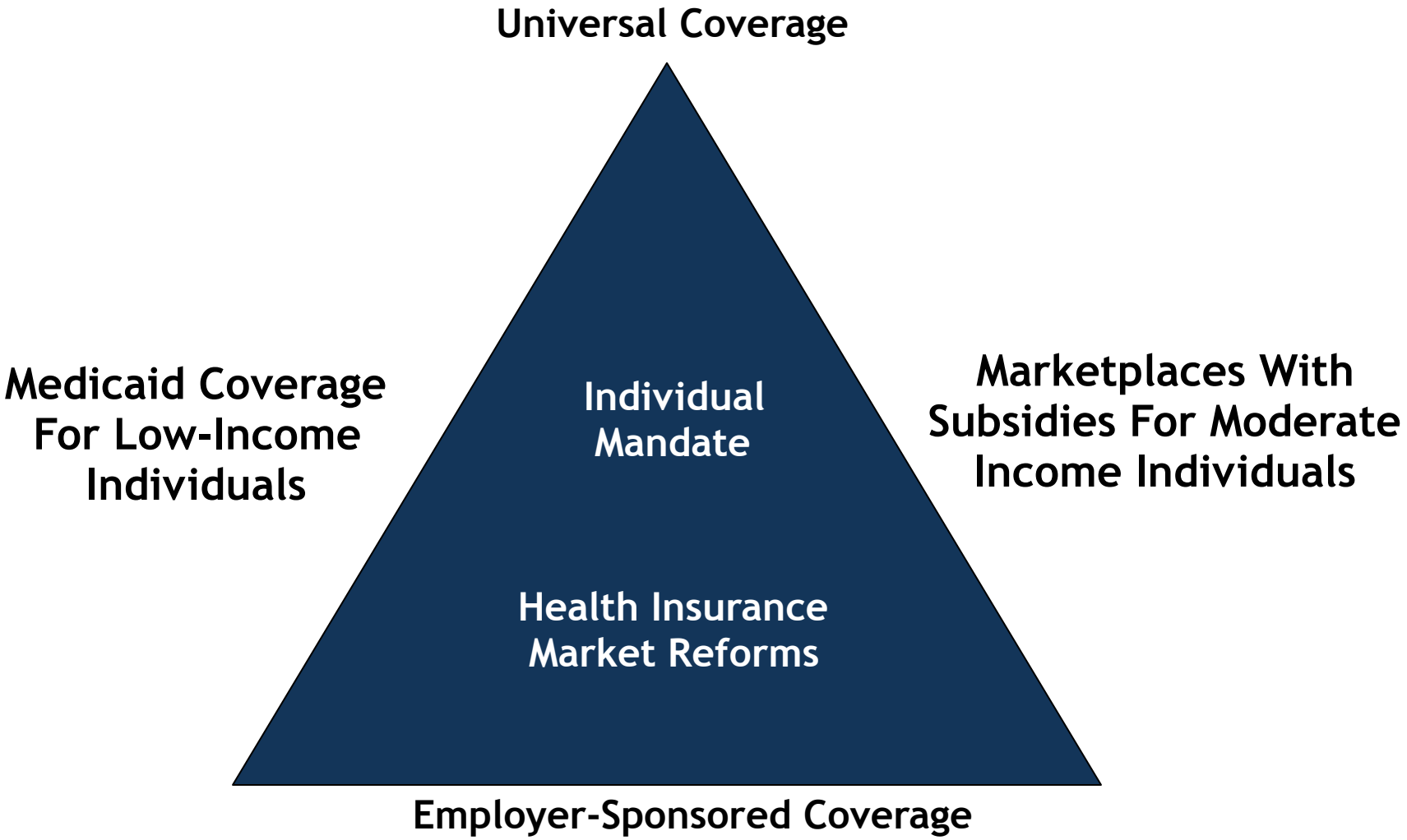
About APHA

APHA is a global community of public health professionals and the collective voice for the health of the public. APHA is the only organization that combines 140 years of perspective, a broad-based constituency and the ability to influence federal policy to advocate for and improve the public's health.

- Founded – April 18, 1872
- 501C(3) & Nonpartisan
- Over 50,000 individual & affiliate members

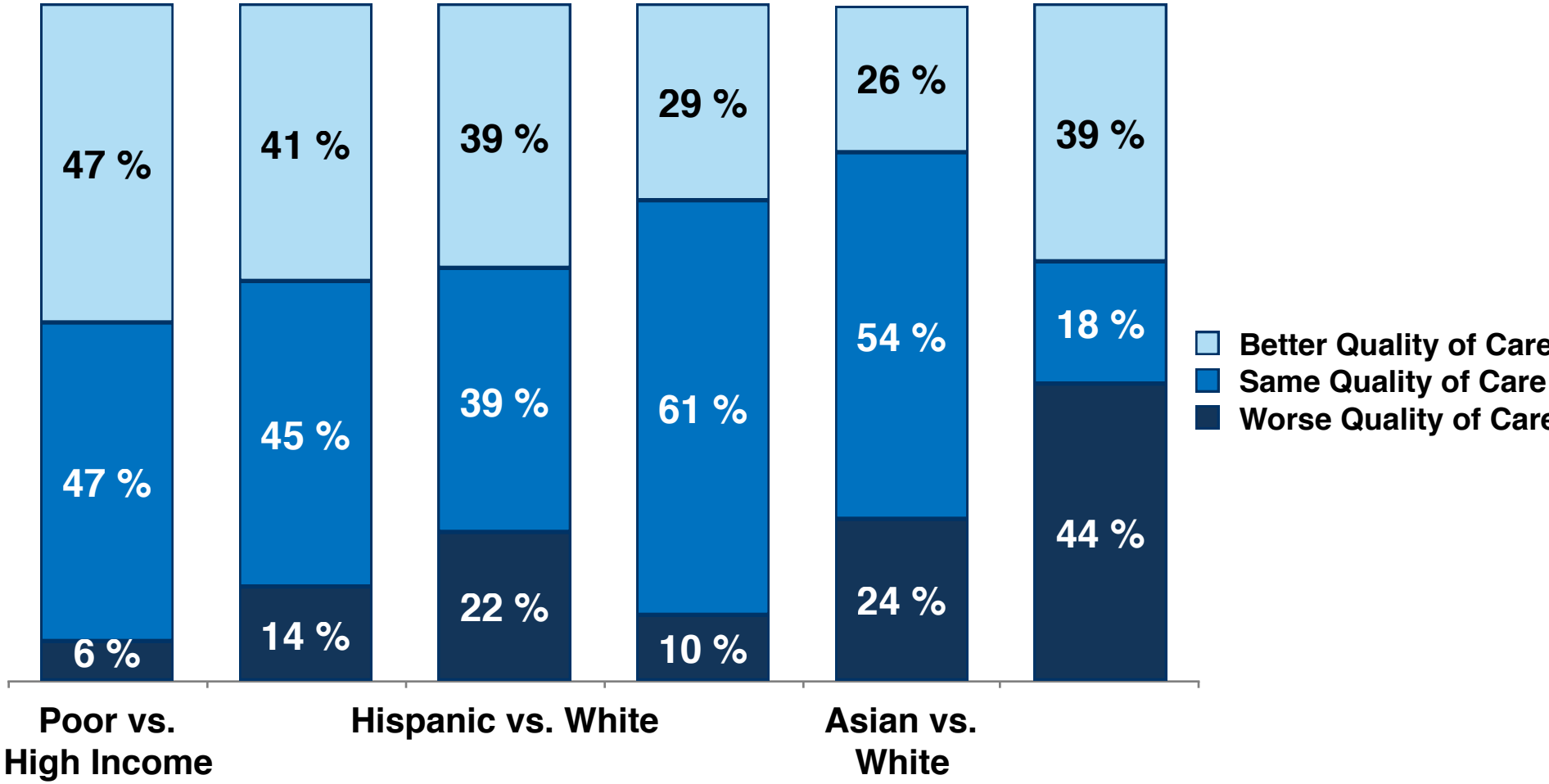
APHA
AMERICAN PUBLIC HEALTH ASSOCIATION

Expanding Medicaid To Low-Income Adults Is A Major Component of the ACA



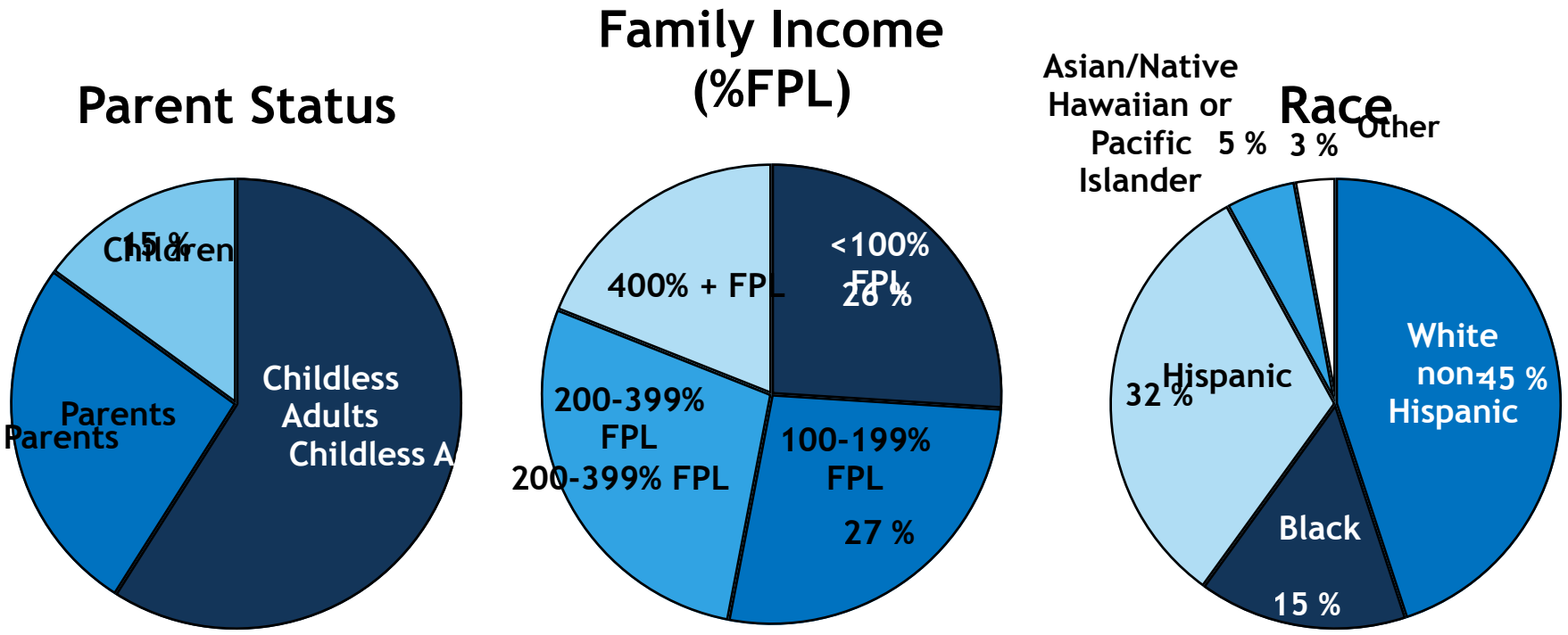
Disparities in Quality of Care for Selected Groups

Percent of quality measures for which groups experienced worse, same, or better quality of care:



AI/AN = American Indian or Alaska Native.
SOURCE: AHRQ, "National Healthcare Disparities Report, 2011, http://www.ahrq.gov/qual/qrdr11.htm

In 2015, the majority of the uninsured are low-income adults, and more than half are people of color.

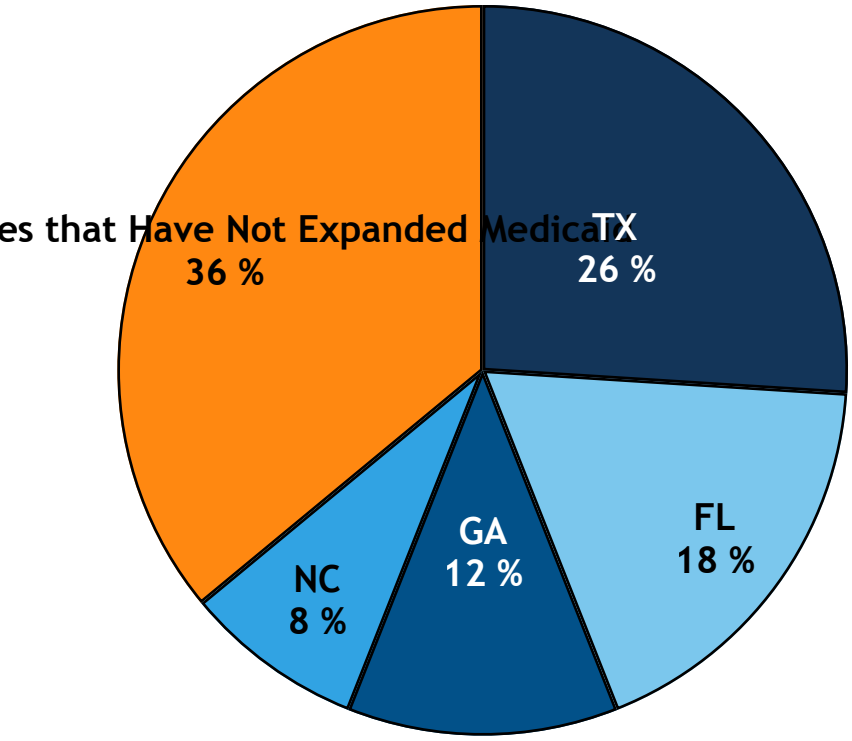


Total = 28.5 Million Uninsured

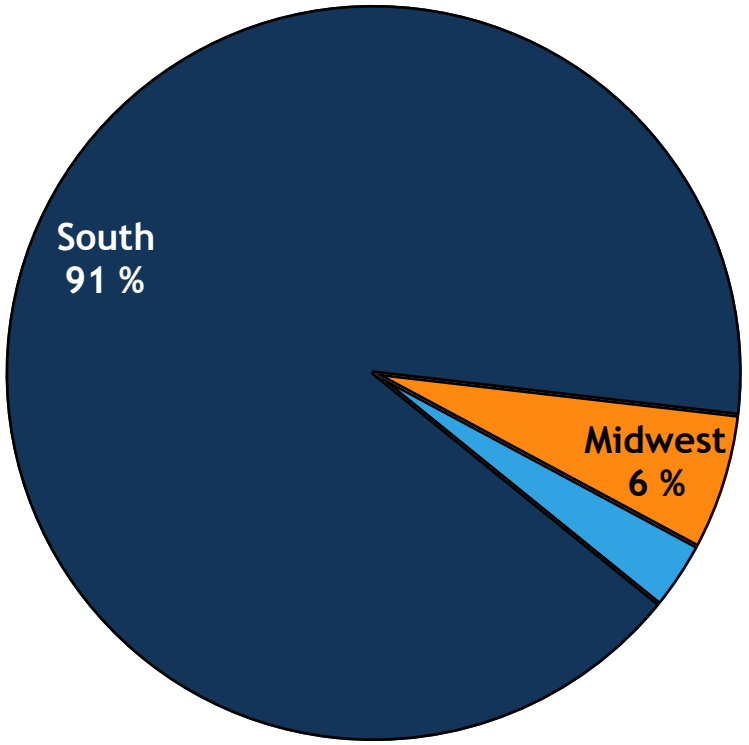
NOTES: The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,078 in 2015. Data may not total 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.

An estimated 2.6 million nonelderly adults fall into the coverage gap, most of whom reside in the South

Distribution By State:



Distribution By Geographic Region:

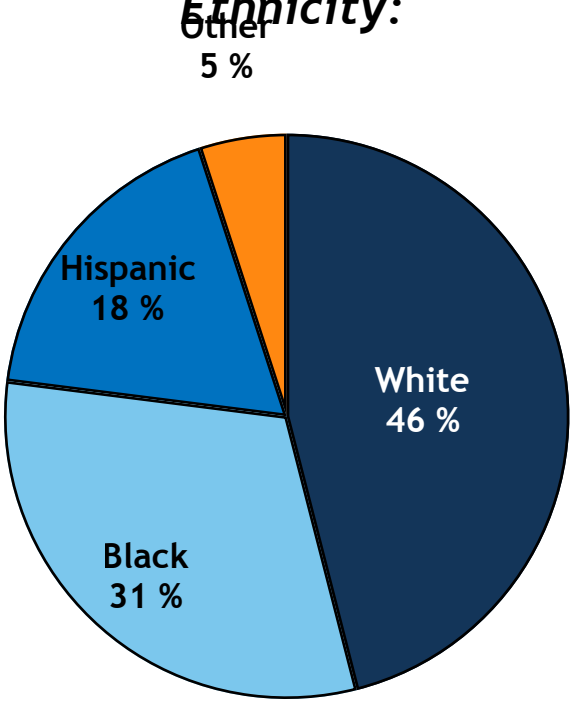


Total = 2.6 Million in the Coverage Gap

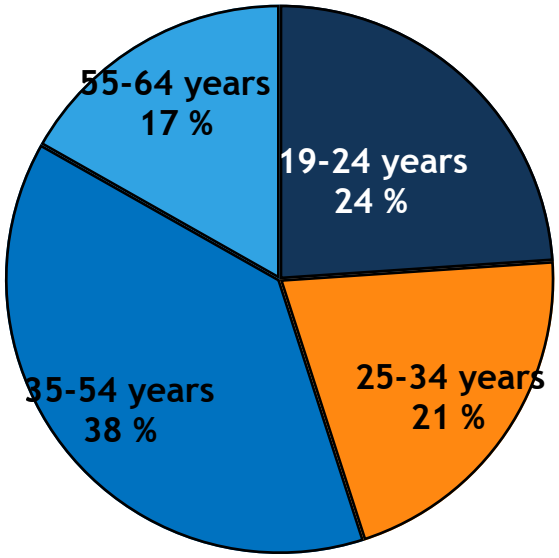
Note: Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey data.

More than half of adults in the coverage gap are adults of color. Adults in the coverage gap are of varying age and health status

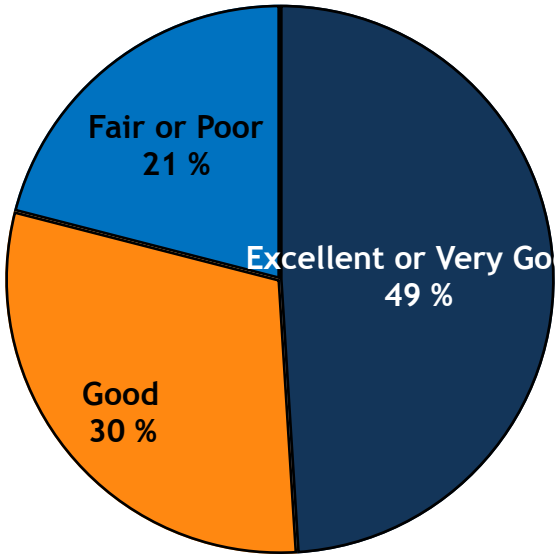
Distribution By Race/ Ethnicity:



Distribution By Age:



Distribution By Health Status:

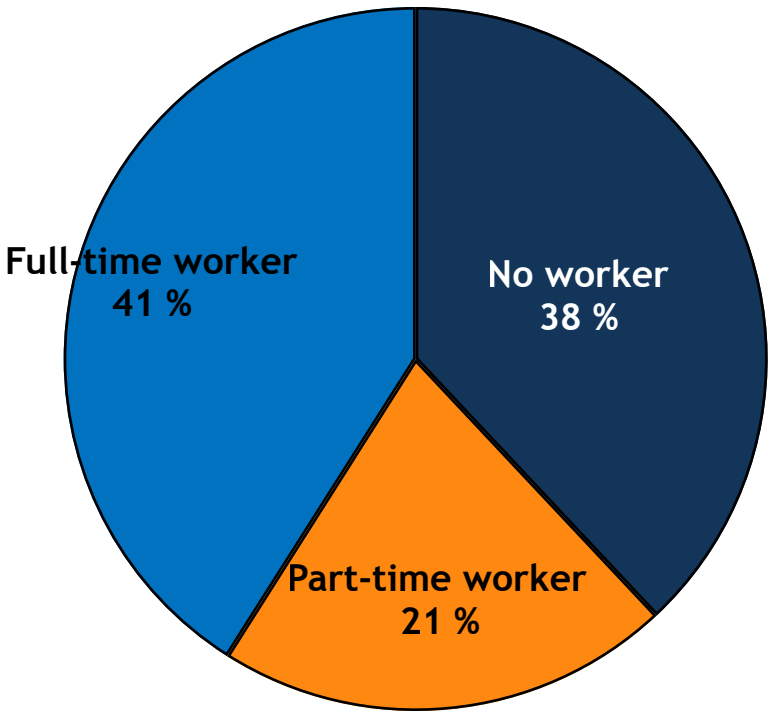


Total = 2.6 Million in the Coverage Gap

Note: Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey data.

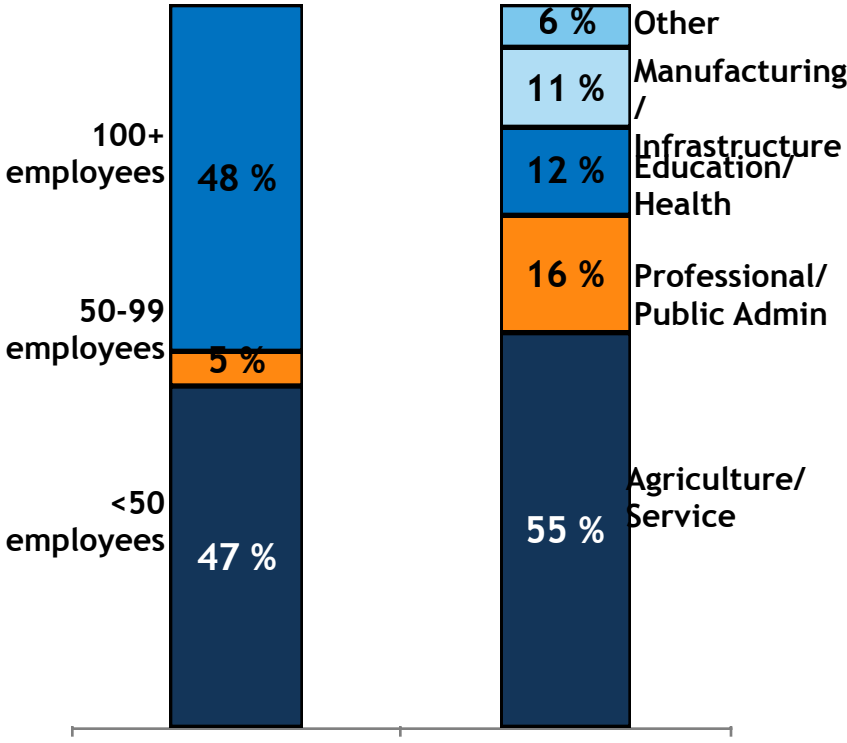
Nearly two-thirds of adults in the coverage gap are in a family with a worker, but most work in jobs that are unlikely to offer insurance

Family work status :



Total = 2.6 Million in the Coverage Gap

Firm size and industry among those working:

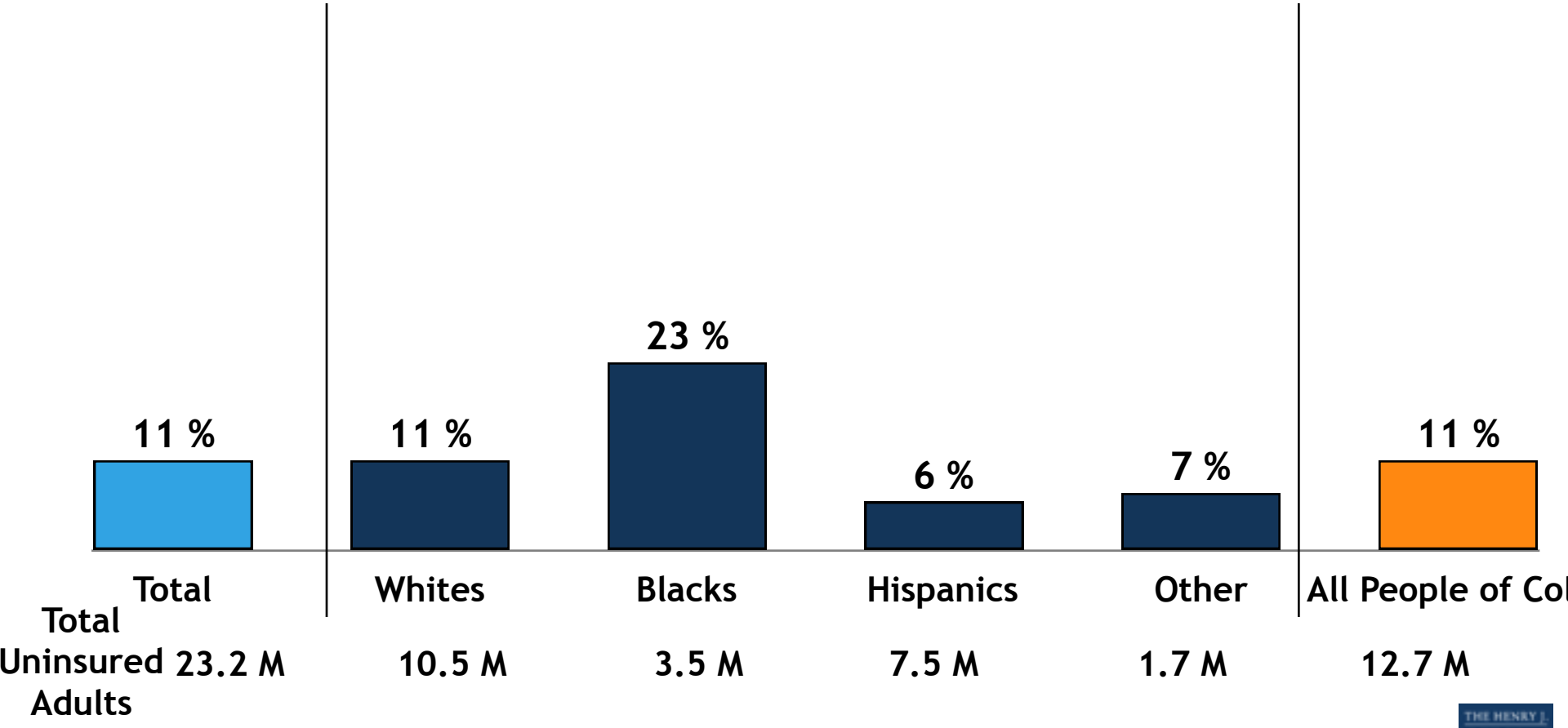


Total = 1.4 Million Workers in the Coverage Gap

Notes: Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation. Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey data.

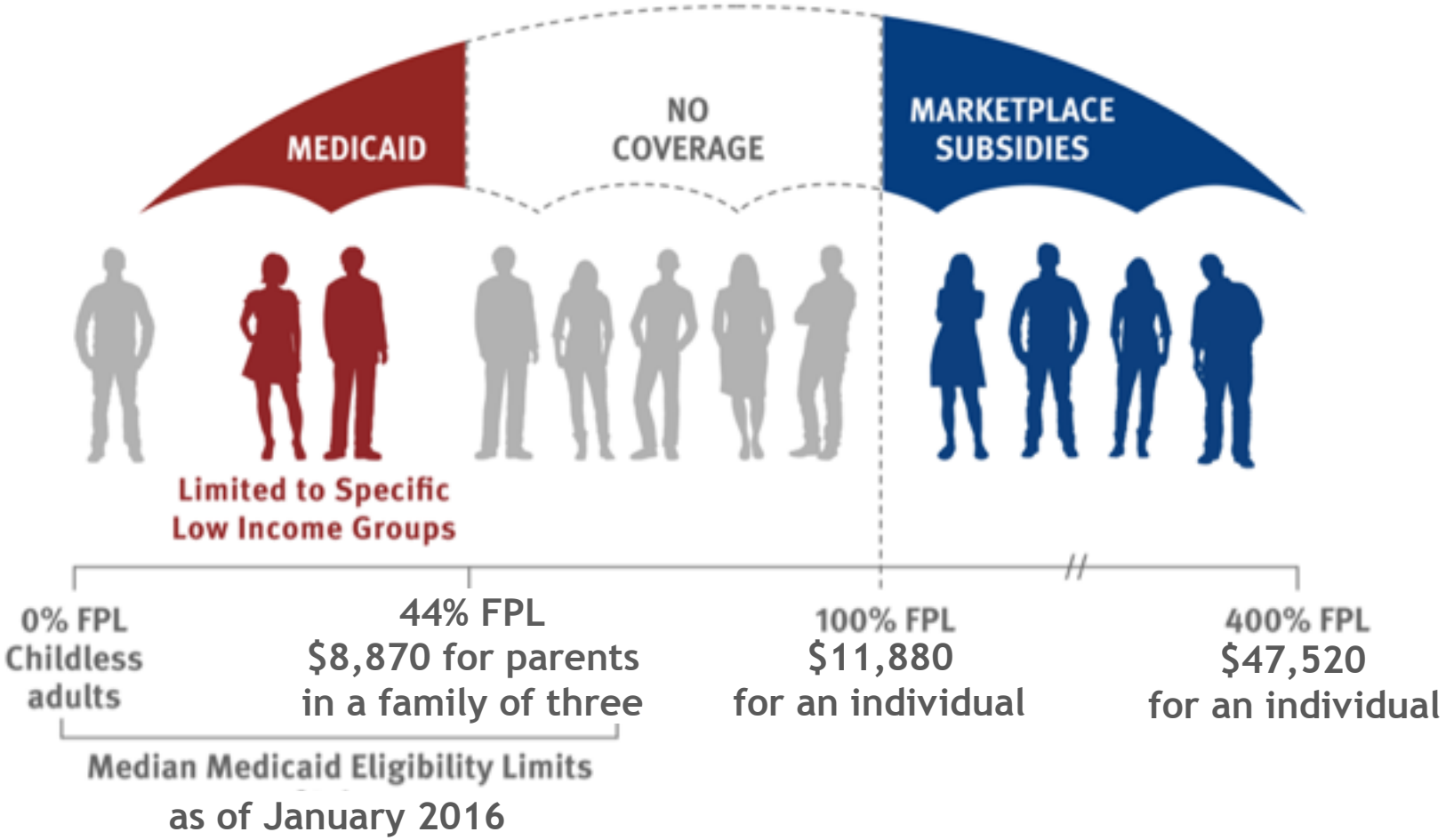
Uninsured Black adults are more likely to fall into the coverage gap than other racial/ethnic groups

Share of Uninsured Adults Who Fall into the Coverage Gap, by Race/ Ethnicity:



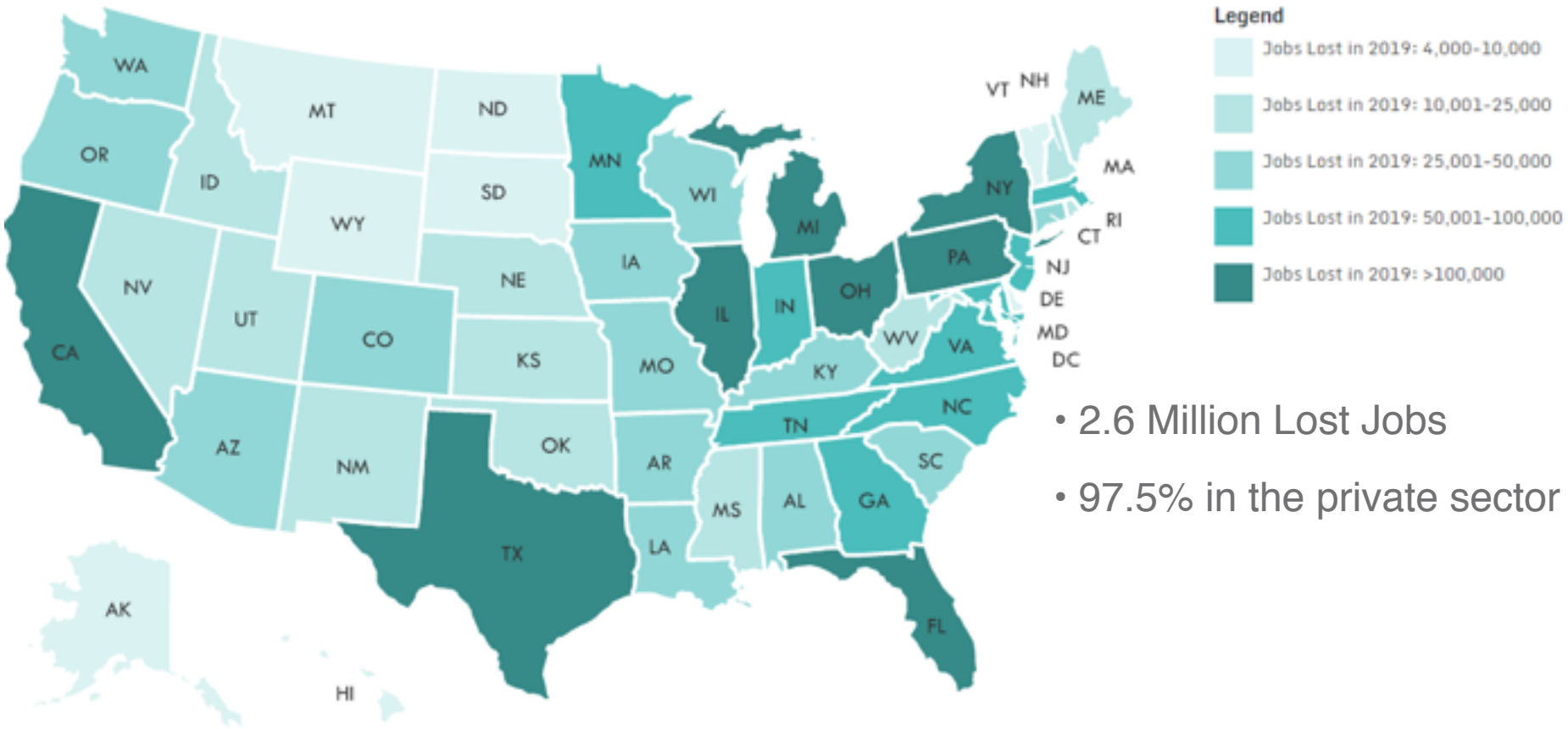
Source: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey data.

In states that have not adopted the Medicaid expansion, poor adults fall into a coverage gap, earning too much to qualify for Medicaid but too little for subsidies for Marketplace coverage



Impact of Repeal on Employment

Repeal of Both Premium Tax Credits and Medicaid Expansion: Potential National Impact

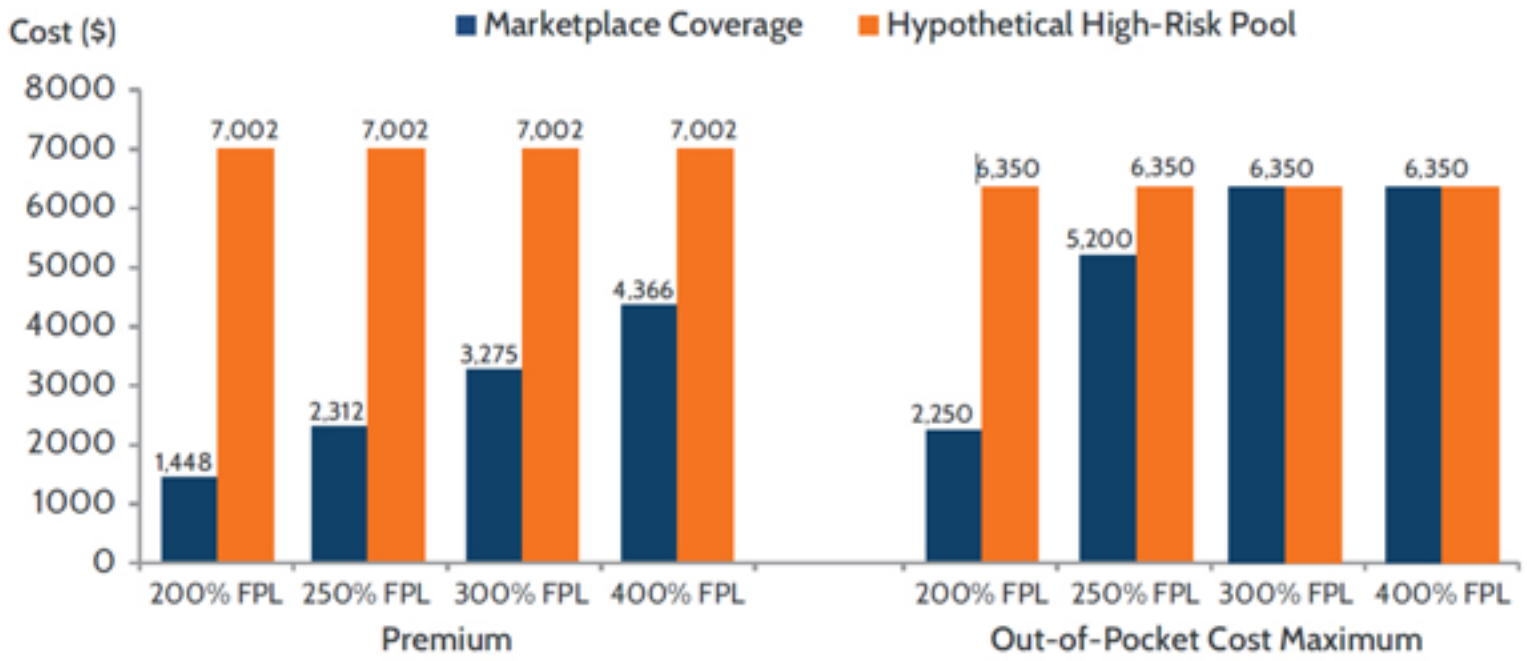


- 2.6 Million Lost Jobs
- 97.5% in the private sector

Source: L. Ku, E. Steinmetz, E. Brantley et al., Repealing Federal Health Reform: Economic and Employment Consequences for States, The Commonwealth Fund, January 2017.

High Risk Pools Costs

Exhibit 1. Premium and Out-of-Pocket Costs for Health Coverage in Marketplace vs. Hypothetical High-Risk Pool



Notes: FPL=federal poverty level. Premium figures are based on those for a 50-year-old single person who has reached the out-of-pocket maximum. Figures based on Kaiser Family Foundation subsidy calculator (http://kff.org/interactive/-subsidy-calculator/). Hypothetical high-risk pool uses national standard risk rate based on federally administered PCIP premiums; see J. P. Hall and J. M. Moore, Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable (New York: The Commonwealth Fund, June 2011).