Direct Care Alliance, Inc.

Direct Care Alliance Policy Brief No. 7

Implementing the Coverage Provisions of Health Care Reform: What's at Stake for Direct Care Workers

By Shawn Fremstad, Center for Economic and Policy Research

In March 2010, President Obama signed landmark health care reform legislation into law.[1] Over the course of the next several years, the new health care law will extend health insurance coverage to an estimated 32 million uninsured Americans and improve health insurance options and health care quality for the vast majority of Americans.[2] The reform will not solve all the problems with our health care system. Of particular concern, some 23 million people will likely remain uninsured. Still, the reform will bring about the most important expansion of health care coverage since the enactment of Medicare 45 years ago.

This policy brief details the key coverage-related provisions of health reform, and discusses steps that direct care workers, direct care associations, and others can take to ensure that the coverage provisions of health reform are implemented in ways that work for direct care workers and employers. Direct care workers have a vital role to play in the implementation process, and may want to advocate for the following:

- a state advisory committee on health reform implementation that includes direct care workers;
- that states take full advantage of new options in the law to streamline eligibility for Medicaid and subsidies for purchasing health care coverage in the exchange;
- the implementation of the Basic Health Plan option for residents with incomes below 200 percent of the poverty line;
- the establishment of a publicly administered health plan to compete in the exchange; and
- the use of federal grants to fund and strengthen independent and effective Consumer Assistance Programs to help consumers navigate the new system.

These recommendations are explained in more detail later in this policy brief. Health reform also includes important provisions related to health care workforce development, long-term care insurance, public health, prevention and many other health-related issues. Although not discussed in this brief, many of these provisions are relevant to direct care workers.[3]

I. Implementing the Key Coverage-Related Provisions on Health Care Reform

The coverage provisions of health reform take effect in roughly two phases.

January 2011

This is the seventh in a series of policy briefs about the direct care workforce in long-term care issued by the Direct Care Alliance (DCA). This series was conceived at a meeting of labor economists, lawyers, long-term care researchers, and other experts convened by the DCA and funded by the Russell Sage Foundation.
Editorial committee: Nancy Folbre, Vera Salter, Leonila Vega.

The Direct Care Alliance

The Direct Care Alliance is the national advocacy voice of direct care workers. We empower workers to speak out for better wages, benefits, respect, and working conditions, so more people can commit to direct care as a career. We also convene powerful allies nationwide to build consensus for change.

First, between this year and 2013, numerous provisions that expand insurance options will be implemented. However, no one who is currently uninsured will be required to obtain insurance. Second, three years from now, in 2014, most businesses with 50 or more full-time employees will be required to provide insurance (or pay a penalty) to employees working more than 30 hours per week, and nearly all uninsured adults will be required to obtain insurance. Financial credits will be available to low- and middle-income families—and to certain small businesses and small non-profit organizations—to offset the cost of coverage. By 2019, some 92 percent of Americans under the age of 65 should have health insurance.[4]

A. PHASE 1 OF HEALTH REFORM IMPLEMENTATION: 2010-2013

A number of important provisions in the law that expand coverage options will go into effect between now and the end of 2013. Some of the most important provisions, including the following, have already taken effect.

➢ **Pre-Existing Condition Insurance Plan (PCIP):** Health care reform creates a new program—the Pre-Existing Condition Insurance Plan—to provide coverage to uninsured people who have been denied insurance because of a pre-existing condition. The Pre-Existing Condition Insurance Plan is now available in all states until 2014, when insurers will be prohibited from denying coverage based on a pre-existing condition. The new plan covers a broad range of health benefits, including treatment of a pre-existing condition, and has no income eligibility limits. You will need to pay a monthly premium, but the premium will not be higher because of your condition. Premiums and other details of the plan generally vary by state; in 23 states and the District of Columbia, PCIP is administered by the federal government.[5] In most states, PCIP has only enrolled about 10 percent or fewer of those potentially eligible, suggesting that many states need to conduct more outreach and marketing to inform the public about PCIP, and review their PCIP policies to ensure that the program is affordable and accessible.[6]

➢ **Coverage for Young Adults:** Young adults are more likely to be uninsured than any other age group. In 2008, nearly 3 out of every 10 young adults (age 18 to 24) were uninsured compared to an overall uninsurance rate of 15.4 percent, and more than one out of every four uninsured Americans were young adults ages 19 to 29. Health care reform will help address this problem by requiring health care plans that offer coverage to children on their parents' plan until the adult child reaches the age of 26.[7] The adult child does need to live with their parents, be a dependent on the parents' tax return, or be a student or unmarried. Health care plans must notify adult children of continued eligibility and give them the opportunity to join their parents' plan beginning on or after September 23, 2010.[8]

➢ **New Health Care Tax Credit for Small Employers:** Small employers, including non-profit employers, are eligible for a tax credit if they cover at least 50 percent of the cost of health care coverage for some or all of their workers. To qualify, an employer must have less than the equivalent of 25 full-time workers, and pay average annual wages below $50,000. For employers with the equivalent of 10 full-time workers and average wages under $25,000, the credit is equal to 35 percent of employers' premium costs. For other small businesses, the value of the credit phases out as the number of employers and/or average wages increases to the 50 FTE/$50,000 annual wages limit. Tax-exempt (non-profit) employers can receive the credit even though they don't pay federal taxes.[9]

➢ **Medicaid and CHIP:** States must at least maintain the Medicaid and CHIP coverage and enrollment procedures that they had as of the date of enactment of the new law (March 23, 2010) until January 1, 2014. However, beginning in 2011, states with budget deficits can seek an exemption from maintaining adult eligibility levels above 133 percent of the poverty line.[10] (As discussed below, states must provide Medicaid coverage for non-elderly up to 133 percent of the federal poverty line starting in 2014).

➢ **Immigrant Eligibility for Medicaid and CHIP:** Under previously established rules that will remain in place, most lawfully residing immigrants are ineligible for federal Medicaid and CHIP during their first five years in the United States (undocumented immigrants are also ineligible, except for emergency Medicaid). More than half of all states already use state funds to provide Medicaid-

like coverage during this period to low-income lawfully residing immigrants. In addition, legislation passed last year provides a new state option to waive the federal five-year requirement for lawfully residing immigrants who are children or pregnant.[11] States that take this option can receive federal Medicaid and CHIP matching funds for the children and pregnant women they cover.

➢ **New Voluntary Long-Term Care Insurance Program:** Health reform establishes a new voluntary long-term care insurance program, known as the Community Living Assistance Standards and Supports (CLASS) program. Under the program, workers will be able to have premiums deducted from their paychecks to purchase long-term care insurance. CLASS will be a public program that is distinct from Medicare and private long-term care insurance. It will provide cash assistance to insured individuals who become disabled or otherwise limited in basic activities of daily living. The assistance can be used to purchase non-medical services and supports necessary to maintain community residence.

B. PHASE II OF HEALTH REFORM IMPLEMENTATION: 2014

➢ **Individual Requirement to Obtain Insurance:** U.S. citizens and legal residents must obtain health insurance or pay a penalty. If a person can't obtain affordable coverage through their employer, or a public program—nearly all individuals and families with incomes below 133 percent of the poverty line will be eligible for Medicaid, as discussed further below —they can purchase coverage through the new "exchanges" established by the law. The cost of this coverage is subsidized for low- and middle-income people. The penalty for not obtaining insurance is the greater of $695 per year up to a maximum of $2,085 per family or 2.5 percent of household income. The penalty does not apply to people with income below the federal income tax filing threshold (in 2009, this was $9,530 for a single non-elderly individual, and $18,700 for couples). In addition, exemptions are available for financial hardship, religious objections, American Indians, those without coverage for less than three months, and those for whom the lowest cost plan option exceeds 8 percent of income.

➢ **Health Exchanges Established:** All states must have exchanges in place where individuals can buy health insurance through private insurers if affordable coverage isn't available through their employers. In addition, small businesses with up to 100 employees can purchase coverage through a Small Business Health Options Program (SHOP) exchange. The exchanges will offer individuals and qualified employers a choice of health plans that meet certain benefits and cost standards. Starting in 2017, states may allow businesses with more than 100 employees to purchase coverage for their employees through the SHOP exchange.

➢ **Benefit Plans Offered Through the Exchange:** Plans offered through the exchange must provide a comprehensive set of services, including pediatric services and preventive care, and cover at least 60 percent of the actuarial value of the covered benefits. Four benefit packages (bronze, silver, gold, platinum) may be offered within the exchanges. These packages will vary by actuarial value (the share of medical expenses the plan pays for a standard population) with the bronze plan at 60 percent of actuarial value and the platinum at 90 percent. The Secretary of Health and Human Services will define and annually update the benefit package through a transparent and public process.

Table 1

FPL	Premium Limit as a Share of Income	Actuarial Value After Cost Sharing Applied	Out of Pocket Limit (Individual/Family)
Below 133%	2%	94%	$1,983/$3,967
133%	3%	94%	$1,983/$3,967
150%	4%	94%	$1,983/$3,967
200%	6.3%	87%	$2,975/$5,950
250%	8.05%	73%	$2,975/$5,950
300-400%	9.5%	70%	$3,967/$7,933

➢ **Individual Tax Credits Available:** Low- and middle-income individuals that will purchase coverage through the exchange will be eligible for tax credits that offset the cost of insurance. Credits will be available for people with incomes below 400 percent of poverty ($43,000 for an individual or $88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage. As Table 1 shows, credits will be set so that the premium contribution in 2014 is not more than 3 percent of income for individuals with income at 133 percent of the

poverty line and no more than 9.5 percent of income for those with income from 300 to 400 percent of the poverty line. People with incomes up to 250 percent of poverty may also qualify for reduced co-payments and deductibles. Eligibility for tax credits will be based on modified adjusted gross income in the most recent tax year (i.e., the prior year to when the subsidy is being sought).

➢ **Increased Access to Medicaid:** People who earn less than 133 percent of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four in 2010) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing down to 90 percent federal funding in subsequent years. Currently, only children are eligible for Medicaid in all states up to 133 percent of poverty; only a few states provide coverage to adults who aren't caring for children, and coverage for parents generally ends at far below the poverty line.[12]

➢ **State Option to Create a Basic Health Plan:** States have the option to create a Basic Health Plan for uninsured individuals with incomes between 133 to 200 percent of the federal poverty line who would otherwise be eligible to receive a tax credit for coverage purchased through the exchange. States will receive 95 percent of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals.

Who Will Get Insurance and Who Will Remain Uninsured?

The Congressional Budget Office (CBO) estimates that by 2019, health reform will reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured. About 29 million people will obtain coverage through the new insurance exchanges (5 million of whom will obtain employment-based coverage through the exchange). An additional 16 million people will enroll in Medicaid and the Children's Health Insurance Program (CHIP). These gains in coverage will be partially offset by declines in people purchasing coverage outside the exchanges and people with employment-based coverage outside the exchanges, resulting in the net increase of 32 million.

Of the 23 million uninsured, CBO has said that about one-third are undocumented immigrants, but has not specified the demographics of the remaining two-thirds of the post-reform uninsured. Research conducted on health care reform in Massachusetts—which the national reform resembles in many respects—suggests that adults who remain uninsured after the reform are more likely than those with coverage to be:[13]

- male, young, and single;
- members of racial and/or ethnic minority groups;
- non-citizens and/or people with limited English proficiency;
- people with low levels of educational attainment.

A substantial portion of those who remain uninsured are likely to be eligible for some form of subsidized health insurance. Thus, as discussed further below, direct care worker associations and employers can play an important role in ensuring that eligible workers and their family members know about their options and obtain insurance.

The Role of State-Based "Exchanges"

The new state-based health insurance exchanges will play a crucial role in the expansion of coverage under health reform.[14] According to the Georgetown Center for Children and Families, about 10 percent of people with health insurance coverage in 2019 (when reform has been fully implemented) will obtain coverage through the exchange, and two-thirds of them will receive a financial subsidy to purchase insurance.[15] A substantial portion of currently uninsured direct care workers—in particular, those with incomes above 133 percent of the poverty line who are ineligible for Medicaid and do not have an affordable coverage option from their employer—will obtain health insurance through an exchange.

States must establish exchanges by January 1, 2014, and will receive federal funding for their initial planning and start-up costs. In states that do not establish exchanges (either by choice or a failure to meet requirements), the federal government will set up and operate an exchange. The federal government will establish general rules for the exchanges, but states have extensive discretion in designing their exchanges.

Exchanges have five primary responsibilities:

- screen and select health plans, based on federally-defined standards, for eligibility to participate in the exchanges;
- assist people and small businesses in making informed

decisions about their coverage options;
• implement and operate application and enrollment procedures, including the determination of applicants' eligibility for premium tax credits and cost-sharing subsidies;
• create "seamless" eligibility and enrollment linkages with Medicaid and CHIP;
• administer the personal and employer responsibility requirements of the law.

Some of the key design decisions that states face include:

➢ **Basic Framework:** A state can establish a single statewide exchange or separate exchanges for specific regions of the state. They can also join with other states to create a multi-state exchange. In addition, states can establish a separate exchange for small businesses. If a state opts to establish separate exchanges, it will be important to ensure that each exchange within the state serves a large enough pool of people to spread risk adequately.

➢ **Non-Profit or Governmental:** States can operate exchanges as either a government agency or a nonprofit organization, or combine the two forms. States may use their existing Medicaid agency to administer exchange functions or tasks, including eligibility for financial subsidies. Because most currently uninsured direct care workers will obtain coverage through either Medicaid or the exchange, this is likely to be the option that works best for them.

➢ **Consumer Consultation:** Exchanges must consult with consumers, small businesses, and individuals or organizations working on behalf of hard-to-reach populations. States should be encouraged to mandate consumer participation and representation in the governance structures they establish for their exchanges.

➢ **Content of Benefit Plans Offered in the Exchanges:** As noted above, plans offered in the exchange must meet minimum federal requirements for benefits. States can go beyond this requirement and mandate additional minimum benefits, but must offset any additional premium costs if they do so.

Finally, exchanges must contract with professional associations and local organizations to provide "Exchange Navigator" services. Navigators will provide the following services:
• conduct public education activities that raise awareness of qualified insurance options;
• distribute information about enrolling in a health plan through the exchange, and about the availability of premium tax credits and cost-sharing reductions;
• facilitate enrollment in a plan through the exchange;
• provide referrals for any enrollee with a grievance, complaint, or question regarding a health plan to an office of health insurance consumer assistance (discussed more below) or appropriate state agency;
• provide information that is culturally and linguistically appropriate to the population being served.

Eligible navigator organizations must demonstrate existing relationships, or the ability to establish relationships, with employers, employees, and other consumers.

The Need for Expanded Outreach, Enrollment, and Consumer Assistance at the State Level

The success of health reform will depend in large part on efforts to educate the currently uninsured about their new options and enroll them in the insurance plan that best meets their needs. Expanded outreach and education efforts should not wait until health reform is fully implemented several years from now. New research shows that millions of Americans who are eligible for health insurance do not receive it. According to the Urban Institute, of the 7.3 million children who were uninsured on an average day in 2008, almost two out of every three (4.7 million children) were eligible for Medicaid or CHIP but not enrolled.[16]

In addition, it will be important to ensure that adequate assistance is available to help millions of newly insured consumers navigate the health care systems. In addition to the navigator programs discussed in the previous sections, states are required to establish a health insurance consumer assistance office (sometimes called an "ombudsman program" or a "health consumer advocate"), and $30 million in federal grant funding is available to establish or strengthen such programs.

Consumer assistance programs are independent of health plans and facilities and help consumers navigate the health insurance and health care systems. They will play a critical role in assuring that the transition to a reformed

system is smooth. Families USA recommends that consumer health assistance programs that are broad in scope should have staff with distinct areas of expertise, including private insurance coverage, self-insured plans, Medicare, Medicaid, and coverage and service options for the uninsured.[17]

Implementation Advocacy and Information

States and the federal government will need to make literally hundreds of policy and program decisions over the next few years as they implement provisions of health reform. In response to federal health reform, many state legislatures and governors have begun setting up state-level infrastructures for implementing the new law. State implementation efforts, to date, include creating task forces or appointing officials responsible for moving forward with federal requirements, and considering and enacting legislation that implements various provisions of the federal law. For example:

- Illinois Governor Pat Quinn issued an Executive Order earlier this year that creates the Illinois Health Reform Implementation Council. The Council is composed of the directors of various state agencies, and will make recommendations to the Governor on health reform implementation. A first report from the council is due by the end of the year.
- California Governor Arnold Schwarzenegger signed legislation in September 2010 that implements various provisions of health care reform, including the establishment of the California Health Benefits Exchange within the state's Health and Human Services Department.[18]

For a list of similar state executive actions as well as state legislation related to health care implementation, see State Actions to Implement Federal Health Reform on the website of the National Conference of State Legislatures.[19]

State direct care worker associations and ally groups should connect with health care coalitions and advocates to determine how to best influence state and federal implementation of reform in a manner that provides the greatest benefits to working families. State-level direct care worker associations should include sessions on health care reform implementation at their meetings and annual conferences. State-level direct care worker associations and individual workers should talk to state legislators and other policymakers to ensure that the voices of direct care workers are taken into account during implementation. Important targets of advocacy at the state level include your Governor's office, state health and human services agencies, state insurance commissioners, and state-level task forces that have been set up to implement reform. Individual direct care workers may also want to talk with their employers about whether they plan to provide coverage to workers (if they aren't already doing so) and what options will available.

State-level direct care worker associations should urge policymakers to implement federal health care reform in a way that ensures direct care workers and those in similar jobs are able to obtain affordable coverage. Specific policies that direct care workers and allies may want to advocate for include:[20]

- having their state establish an advisory committee on health reform implementation that includes direct care workers and workers in other occupations (including child care, domestic service, accommodation and food service) and that have the lowest rates of health insurance coverage;
- ensuring that their state takes full advantage of new options in the law to streamline eligibility for Medicaid and subsidies for purchasing health care coverage in the exchange;
- having their state implement the Basic Health Plan option for residents with incomes below 200 percent of the poverty line (roughly $44,000 for a family of four) who are ineligible for Medicaid because of income or immigration status)—this option may be more affordable and easier to access for many workers in lower-income households than purchasing subsidized insurance through the exchange;
- establishing a publicly administered health plan to compete in the exchange—this would increase the options available to customers seeking insurance in the exchange, and could push private insurance to improve the quality and lower the costs of their plans in order to stay competitive;[21] and
- using federal grants to fund and strengthen independent and effective Consumer Assistance Programs (also known as ombudsman or consumer advocate programs) to help consumers navigate the new system and bring problems to the attention of state officials.

At the federal level, various agencies will be issuing regulations and guidance over the next several years to implement health care reform. For the latest opportunities, see the Regulations page on the healthcare.gov website.[22] Important future opportunities will likely include regulations and guidance related to the new Community Living Services and Supports (CLASS) program (see discussion above on page 3), the design of benefit plans offered

through the exchanges, Medicaid expansion, and the state option to create a Basic Health Plan.

Defending the Reforms

Legislators in at least 39 states have proposed legislation to limit, alter or oppose selected state or federal health reforms.[23] In addition, some groups and members of Congress have called for outright repeal of the law. Many of these proposals would undermine the effectiveness of health care reform for direct care workers and others with high rates of uninsurance.

Some opponents of health care reform that extends coverage to uninsured Americans have argued that the new law will increase the federal deficit or impose unaffordable new costs on states. These claims are incorrect. According to the Congressional Budget Office, the new law will *reduce* the federal budget deficit over the next decade, while proposals to repeal the law would increase the deficit. At the state level, there will be some new costs in most states associated with the expansion of Medicaid to all non-elderly adults with incomes below 133 percent of the poverty level, but because the federal government is paying for 90 percent of the expansion costs (and a greater share in the first five years of implementation), these costs are extremely modest relative to the benefits to states. The Urban Institute estimates that the Medicaid expansion will reduce the number of low-income uninsured adults by nearly 45 percent, while increasing state spending on Medicaid by only 1.4 percent.[24] Table 2 provides the same numbers for all states and the District of Columbia.

For More Information

To learn more about advocacy on health care reform, and how direct care workers can make a difference in their states, contact David Ward, the Direct Care Alliance's Director of Policy and Planning. In addition to DCA, key non-governmental sources of information on health care reform implementation include: www.HealthCare.gov, a federal government website maintained by the U.S. Department of Health and Human Services, Families USA (see their Health Reform Central webpage); Health Care for America Now; the Center for Children and Families at the Georgetown University Health Policy Institute; the National Academy of State Health Policy; and PHI's Health Care for Health Care Workers initiative.

Table 2 Source: Holahan and Headen (2010)

State	Reduction in Uninsured Low-Income Adults	Increase in State Spending on Medicaid
Alabama	53.2%	3.6%
Alaska	48.4%	2.1%
Arizona	13.6%	0.2%
Arkansas	47.6%	4.7%
California	41.5%	1.5%
Colorado	50.0%	1.8%
Connecticut	48.0%	1.2%
Delaware	15.9%	0.1%
District of Columbia	49.1%	0.9%
Florida	44.4%	1.9%
Georgia	49.4%	2.7%
Hawaii	50.0%	0.5%
Idaho	53.9%	2.5%
Illinois	42.5%	1.6%
Indiana	44.2%	2.5%
Iowa	44.1%	1.4%
Kansas	50.9%	1.7%
Kentucky	57.1%	3.5%
Louisiana	50.7%	1.7%
Maine	47.4%	1.5%
Maryland	46.2%	1.7%
Massachusetts	10.2%	2.1%
Michigan	50.6%	2.0%
Minnesota	44.2%	1.2%
Mississippi	54.9%	4.8%
Missouri	45.5%	1.7%
Montana	49.6%	3.7%
Nebraska	53.9%	1.5%
Nevada	47.0%	2.9%
New Hampshire	48.7%	1.1%
New Jersey	45.3%	1.2%
New Mexico	52.6%	2.1%
New York	14.8%	0.0%
North	45.1%	1.4%
North Carolina	46.6%	2.6%
Ohio	50.0%	1.6%
Oklahoma	53.1%	4.0%
Oregon	56.7%	3.6%
Pennsylvania	41.4%	1.4%
Rhode Island	50.6%	0.7%
South Carolina	56.4%	3.6%
South Dakota	51.9%	1.1%
Tennessee	43.3%	2.5%
Texas	49.4%	3.0%
Utah	52.5%	3.7%
Vermont	10.2%	0.6%
Virginia	50.6%	1.8%
Washington	52.2%	1.2%
West Virginia	56.7%	2.4%
Wisconsin	50.6%	0.9%
Wyoming	53.0%	1.2%

What Difference Will Health Reform Make for Direct Care Workers?

Source: This chart is a modified version of "What Will Health Reform Do For You?, an online chart produced by Health Care for America Now (HCAN), and available at: http://healthcareforamericanow.org/.

I...	Phase 1: 2010-2013	Phase 2: 2014
Have insurance through my job	Your children cannot be denied care for pre-existing conditions. Your insurance company cannot cancel your plan because you get sick or put a lifetime benefit limit on your coverage. Annual benefit limits on coverage will be tightly regulated. If you work for a small business with 25 or fewer employees, your insurance should be more secure because your employer may be able to deduct up to 35 percent of its health care premium costs from their taxes. All insurance plans will have to report how much of your premiums they spend on care. If they take too much in profits (more than 15% or 20% depending on the type of plan), and spend too little on care, they must rebate part of what you paid. (January 2011).	All insurance policies will have to offer you coverage regardless of whether you have a pre-existing condition, and won't be able to charge you more because you get sick. They won't be able to put lifetime or annual caps on your benefits and your out-of-pocket costs will be limited. All insurance policies will have to offer at least a standard comprehensive benefit package that is equivalent to what the largest employers offer their employees. This package must include free preventive care, including routine vaccines and screenings. If you work for a business of 100 employees or fewer, your employer can choose to offer you insurance through your state's exchange or a special small business exchange. Or, if you qualify, you'll be able to take the amount your boss pays for your insurance and use it instead to choose a plan on your own in the exchange. In the exchange, you'll be able to compare insurance policies apples-to-apples so you know exactly what you're buying. And you'll receive a tax credit from the government to help you afford insurance. The amount of your tax credit depends on your income and family size, among other things. If you work for a small businesses with 25 or fewer employees, your employer will be able to deduct up to 50% of their health care premium costs from their taxes, making the cost of coverage cheaper. If you work for a large business, your employer will be required to provide insurance for you (and your family) and pay a decent percentage of that coverage.
Have insurance that I buy in the individual market	Your insurance company will no longer be able to cancel your plan because you get sick or put a lifetime benefit limit on your coverage. Annual benefit limits on coverage will be tightly regulated. Your insurance company will have to offer you "first-dollar" coverage of preventative care, which means they have to pay for it even if you haven't paid your full deductible. Your children won't be denied care for pre-existing conditions. All insurance plans will have to report how much of your premiums they spend on care and rebate part of what you pay if they take too much for profits. (Jan. 2011).	If you like your insurance plan, you can keep it. If you don't, you can purchase insurance in your state's health insurance exchange, a purchasing pool where subsidies are offered to make insurance affordable. Alternatively, you can buy it in the open market (like insurance is sold today but with greater regulation). In the exchange, you'll be able to compare insurance policies apples-to-apples so you know exactly what you're buying. And you'll receive a tax credit from the government to help you afford insurance. The amount of your tax credit will depend on your income, family size, and certain other factors. All insurance policies will have to offer at least a standard comprehensive benefit package—including free preventative care—that's equivalent to what the largest employers offer their employees. Any policy will have to offer you coverage regardless of whether you have a pre-existing condition, and insurers won't be able to charge you more if you're sick or a woman. They won't be able to put lifetime or annual caps on your benefits, your out-of-pocket costs will be limited, and they won't be able to jack up your rates with impunity.
Am younger than 26 years old	You can stay on or go back on your parent's insurance plan until you are 26 years old if you don't have access to your own insurance through an employer.	
Am insured through Medicaid or CHIP	You can still get Medicaid or CHIP as long as you continue to meet existing eligibility requirements. State Medicaid programs are required to continue existing coverage.	You will be able to renew your eligibility for Medicaid or CHIP online.

(cont'd on page 9)

What Difference Will Health Reform Make for Direct Care Workers? *(cont'd from page 8)*

I...	Phase 1: 2010-2013	Phase 2: 2014
Am uninsured and have family income below 133% of the poverty line	If you've been denied insurance due to a pre-existing condition, you can get coverage through a temporary reduced rate high-risk pool, which won't be able to deny you coverage due to pre-existing conditions.	You will be eligible for Medicaid, an insurance program run by the federal government and your state that will provide you with comprehensive care at little to no cost. You cannot be denied eligibility because of savings or other assets. You will be able to submit an application for Medicaid and CHIP online, by mail, by phone or in person.
Am uninsured and have family income above 133% of the poverty line		You will be required to purchase affordable insurance. You can either buy it in the open market (like insurance is sold today but with greater regulation) or through your state's health insurance exchange, a purchasing pool where subsidies are offered to make insurance affordable. All insurance policies will have to offer at least a standard comprehensive benefit package—including free preventative care—that's equivalent to what the largest employers offer their employees. Any policy will have to offer you coverage regardless of whether you have a pre-existing condition, and insurers won't be able to charge you more if you're sick or a woman. They won't be able to put lifetime or annual caps on your benefits, your out-of-pocket costs will be limited, and they won't be able to jack up your rates with impunity. In the exchange, you'll be able to compare insurance policies apples-to-apples so you know exactly what you're buying. If you have income below 400 percent of poverty ($43,000 for an individual or $88,000 for a family of four in 2010), you will receive a tax credit to help you afford insurance. The amount of your tax credit will depend on your income, family size, and certain other factors. You many also qualify for reduced cost-sharing (e.g. copayments, coinsurance, and deductibles).
Am a small business owner with 25 or fewer employees	You may be able to deduct up to 35% of employee health care costs from your taxes. To qualify, you have to pay average annual wages below $50,000. Your insurance company will no longer be able to cancel plans because employees get sick or put a lifetime benefit limit on their coverage. Annual benefit limits on coverage will be tightly regulated as well, making insurance better for your employees.	You will be able to deduct up to 50% of health care costs (depending on average wages) from your taxes. Insurance policies will have to offer coverage regardless of whether employees have a pre-existing condition, and they won't be able to charge more for employees who are sick or a woman. Insurers won't be able to put lifetime or annual caps on benefits and out-of-pocket costs will be limited. If you run business of 100 employees or fewer, you can choose to offer your employees insurance through your state's exchange or a special small business exchange. All insurance policies will have to offer at least a standard comprehensive benefit package—including free preventative care—that is equivalent to what the largest employers offer their employees.
Am a small tax-exempt, non-profit employer	You can claim the small-employer tax credit described above (but limited to 25% of health care costs). The credit may be claimed against payroll taxes that tax-exempt organizations pay to the IRS.	You can claim the small-employer tax credit described above (but limited to 35% of health care costs). The credit may be claimed against payroll taxes that tax-exempt organizations pay to the IRS.
Am a business owner with more than 25 employees	Your insurance company will no longer be able to cancel plans because employees get sick or put a lifetime benefit limit on their coverage. Annual benefit limits on coverage will be tightly regulated as well, making insurance better for your employees.	Insurance policies will have to offer coverage regardless of whether employees have a pre-existing condition, and they won't be able to charge more for employees who are sick or a woman. Insurers won't be able to put lifetime or annual caps on benefits and out-of-pocket costs will be limited. All insurance policies will have to offer at least a standard comprehensive benefit package - including free preventative care - that is equivalent to what the largest employers offer their employees. If you have 100 employees or fewer, you can choose to offer your employees insurance through your state's exchange or a special small business exchange. If you have 50 or more full-time employees, you may be subject to a penalty or "shared responsibility" payment" if one or more of your full-time employees receives an individual tax credit or cost-sharing reductions under the health plan they're enrolled in through the state insurance exchange.

End Notes

[1] The legislation is the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148), and, following that, the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) which made a number of changes to provisions of PPACA. The combined legislation is commonly referred to as the Affordable Care Act or ACA.

[2] Congressional Budget Office, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[3] For more on the workforce development provisions related to direct care work, see PHI,Workforce Development and Training Opportunities for Direct-Care Workers, Health Reform Facts 1, June 2010, http://directcareclearinghouse.org/download/HCHCW%20HealthCare%20Fact-Sheet1.pdf.

[4] For details on how many uninsured in your state will gain coverage, and how many small businesses will qualify for tax credits, see the Families USA map at: http://www.familiesusa.org/health-reform-central/from-the-states/from-the-states.html.

[5] To learn more about the plan in your state, see the PCIP Map (http://www.familiesusa.org/health-reform-central/from-the-states/from-the-states.html) at HealthCare.gov, and see PHI's fact sheet on the pre-existing condition plan.

[6] See Bill Toland, Pennsylvania Leads in High-Risk Enrollment, Pittsburgh Post-Gazette, November 9, 2010, http://www.post-gazette.com/pg/10313/1101759-28.stm.

[7] Some states, including New York, New Jersey, and Florida already go further and allow adult children to remain on a parent's policy until age 30 or 31. See National Conference of State Legislatures, Covering Young Adults Through their Parent's or Guardian's Health Policy, http://www.ncsl.org/default.aspx?tabid=14497.

[8] For more information, see this fact sheet from the U.S. Department of Health and Human Services.

[9] For more information, see the Small Business Health Care Tax Credit page on the IRS website, and PHI's fact sheet on the credit.

[10] See Center for Children and Families, Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform, April 2010, http://directcareclearinghouse.org/download/HCHCW%20HealthCare%20Fact-Sheet1.pdf.

[11] The legislation is the Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3. For more on this new option, see Families USA, Expanding Coverage for Recent Immigrants: CHIPRA Gives States New Options, August 2010, http://www.familiesusa.org/assets/pdfs/chipra/immigrant-coverage.pdf.

[12] For more information on current state eligibility rules for Medicaid, see Kaiser Family Foundation, State Medicaid Fact Sheets, http://www.statehealthfacts.org/medicaid.jsp.

[13] Sharon K. Long, Lokendra Phadera, and Victoria Lynch, Massachusetts Health Reform in 2008: Who are the Remaining Uninsured Adults, August 2010, http://www.rwjf.org/files/research/67248.MassReform2008UninsuredBrief.pdf.

[14] For more on the important role of exchanges, and the design decisions states will need to make, see: Families USA, Implementing Health Insurance Exchanges: A Guide to State Activities and Choices, October 2010; Georgetown Center on Children and Families, Health Insurance Exchanges: New Coverage Options for Children and Families, August 2010; and National Academy for State Health Policy, State Policymakers' Priorities for Successful Implementation of Health Reform, May 2010.

[15] See Figure 1 in Georgetown Center on Children and Families, Health Insurance Exchanges: New Coverage Options for Children and Families, August 2010.

[16] Genevieve M. Kenney, Victoria Lynch, Allison Cook, and Samantha Phong, Who Are and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?, Health Affairs 29, No. 10 (2010), http://images.gmimage3.com/members/18967/ftp/Newsletter/Kenney_final.pdf.

[17] Families USA, Designing a Consumer Health Assistance Program, August 2010, http://www.familiesusa.org/assets/pdfs/Designing-Consumer-Health-Assistance-Programs.pdf.

[18] Senate Bill No. 900, Chapter 659, http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.pdf.

[19] National Council of State Legislatures, State Actions to Implement Federal Health Reform, updated October 20, 2010, http://www.ncsl.org/default.aspx?tabid=20231.

[20] For more on these and other state-level implementation issues, see Stan Dorn, *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*, State Coverage Initiatives, updated September 3, 2010, http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Updated_9.3.2010.pdf.

[21] See Families USA, Implementing Health Insurance Exchanges, October 2010, pp. 25-26.

[22] http://www.healthcare.gov/center/regulations.

[23] For more on efforts to repeal or block the law, see the Roadblocks to Implementation page on the Families USA website, http://www.familiesusa.org/health-reform-central/roadblocks-to-new-law.html.

[24] John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, May 2010, Kaiser Commission on Medicaid and the Uninsured.

Acknowledgment

We are grateful to the Russell Sage Foundation, whose generous support made both our initial meeting and this policy brief series possible.

We are also grateful to the following for their invaluable ideas and input:

Randy Albelda, University of Massachusetts, Boston
Eileen Appelbaum, Rutgers University
Christine Bishop, Brandeis University
Aixa Cintron Velez, Russell Sage Foundation
Hector Cordero-Guzman, Ford Foundation
Laura Dresser, Center on Wisconsin Strategy
Mignon Duffy, University of Massachusetts, Lowell
Roy Gedat, Direct Care Alliance
Janet Gornick, CUNY Graduate Center
Candace Howes, Connecticut College
David Kieffer, Service Employees International Union
Carrie Leana, University of Pittsburgh
Nancy McKenzie, Hunter College
Eric Wanner, Russell Sage Foundation
Kelly Westphalen, Russell Sage Foundation