Utah FOUNDATION

Utah Priorities Brief

The top issues facing Utah in 2012

October 2012

Priority Issue #4: Healthcare

Each gubernatorial election year since 2004, Utah Foundation organizes the Utah Priorities Project in partnership with the Hinckley Institute of Politics. The project is designed to engage the public and political candidates in serious dialogue on the most important issues facing our state. It begins with survey work that establishes what voters view as the top ten issues for the election year. This month, Utah Foundation releases a series of policy briefs of each of the top ten issues. In 2012, voters listed healthcare as the fourth most important priority in the election year. This is the same ranking this issue had in the 2004, 2008 and 2010 elections.

In the 2012 Utah Priorities Survey, 69% of respondents indicated that they were concerned or very concerned with healthcare, making it the fourth most important issue to voters in this election. Healthcare has consistently been an important issue to voters throughout the past decade, but as indicated by this survey, they are even more concerned with it in 2012.[1]

The Utah Priorities Survey of Delegates and Voters, which was conducted a few months after the Priorities survey, asked more detailed questions about healthcare. The results of this survey affirm that healthcare is not only an important issue to voters, but a divisive one as well. When asked about important issues that state officials should address, 67% of Democratic voters felt it was important to lower the costs of healthcare, compared to 47% of Republican voters. Similarly, 74% of Democratic voters felt it was important to expand the availability of healthcare coverage, compared to just 40% of Republican voters.[2]

Healthcare has been a prominent political issue in the United States for decades, but the recent increase in concern is likely due to the heated political debate over the Patient Protection and Affordable Care Act (ACA), more commonly known as Obamacare. After months of formal debate in Congress, the ACA was signed into law on March 23, 2010.

The passage of this law did not mark the end of the debate, as opponents introduced legislation to repeal the ACA the day after the president signed it. Since it was passed, dozens of votes have taken place to repeal or defund portions of the law. Similarly, immediately following the Supreme Court decision that upheld ACA, opponents once again vowed to repeal it.

Major components of the ACA

Pre-existing conditions: Individuals cannot be denied insurance coverage because of pre-existing medical conditions. In addition, insurers will be required to offer the same premiums to all applicants of the same age and location regardless of gender or pre-existing conditions.

Individual mandate: All individuals are required to have insurance. Those who are not covered by an employer-sponsored health plan, Medicaid, Medicare or other public plan, must purchase an insurance policy or pay a penalty unless they fall under one of the few exemptions provided in the law. This

Timeline of Major ACA Policies

May, 2010 (at enactment)	The FDA is authorized to approve generic versions of certain drugs and allows certain drug manufacturers 12 years of exclusive use before generics can be developed.
	The Medicaid drug rebate for brand name drugs is increased and extended.
	Certain chain restaurants are required to display the caloric content of their foods on menus and vending machines.
June 21, 2010	Adults with pre-existing conditions are eligible to join a temporary high-risk pool, to be replaced by the health care exchange in 2014.
Sep 23, 2010	Insurers are prohibited from imposing lifetime dollar limits on essential benefits, dropping policy holders when they get sick, and their abilities to enforce annual spending caps are restricted.
	Dependent children are allowed to remain on their parents' insurance plans until the age of 26.
	Children cannot be denied health insurance because of pre-existing conditions.
	All new insurance plans must cover preventive care and medical screenings of certain ratings, and cannot charge co-payments or deductibles for these services.
	All new insurance plans must include childhood immunizations and recommended adult vaccinations.
	Individuals affected by the Medicare "donut hole" will receive a $250 rebate.
Jan 1, 2011	Medical Loss Ratio: Insurers must spend 80-85% of premium dollars on health costs and claims.
	Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap and begins phasing-in federal subsidies for generic prescriptions.
Mar 23, 2011	Provides grants to states to begin planning for American Health Benefit Exchanges and Small Business Health Options Program Exchanges.
Sept 1, 2011	The "Rate Review" policy goes into effect: all health insurance companies must inform the public when they will increase health insurance rates by 10% or more.
Aug 1, 2012	All new insurance plans must cover preventative services without charging a co-pay, co-insurance or deductible.
Jan 1, 2013	A tax of 0.9% will be imposed on individuals with an annual income above $200,000 or married couples filing jointly with annual income above $250,000.
Aug 1, 2013	Religious organizations are no longer exempt from the contraceptive mandate.
Jan 1, 2014	Insurers cannot charge higher rates based on gender or pre-existing conditions.
	An annual penalty of $95, or up to 1% of income (whichever is greater), is levied on individuals not covered by an acceptable insurance policy.
	Medicaid eligibility is expanded in certain states.
	Health insurance exchanges are established.
Oct 1, 2015	States can transfer children currently covered by CHIP to health care plans sold on their exchanges.
Jan 1, 2016	States are permitted to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.
Jan 1, 2018	A 40% excise tax on high cost "Cadillac" insurance plans is introduced.
	All existing health insurance plans must cover approved preventive care and checkups without co-payment.
Jan 1, 2020	The Medicare Part D "donut hole" is completely closed.

portion of the law was especially controversial, but the penalty was upheld as a tax by the U.S. Supreme Court under *National Federation of Independent Business v. Sebelius*.

Health insurance exchanges: Each state will offer a health insurance exchange where individuals and small businesses can compare policies and premiums and ultimately purchase insurance. Low-income individuals and families will receive federal subsidies if they choose to purchase insurance through such an exchange.

Expansion of Medicaid eligibility: Medicaid eligibility will expand to include all individuals and families at or below 133% of the poverty level. The U.S. Supreme Court allowed states to opt out of this expansion. Utah's Governor Gary Herbert has indicated that he is not completely against this expansion, but believes the federal government should allow states more flexibility to provide healthcare.[3]

Preventive Care: Co-payments and deductibles will be eliminated for certain health care insurance benefits considered to be preventive care, such as annual doctors' visits or certain types of screenings.

Medicare Part D Coverage Gap: Currently, when beneficiaries of Medicare reach the prescription drug coverage limit, they become financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold. Because of the ACA, individuals who fall in this "donut hole" will receive significant savings.[4]

The Affordable Care Act and the Federal Budget

In March 2011, the Congressional Budget Office estimated that for the 2012–2021 period, the ACA would increase direct spending by a cumulative $604 billion. The ACA raises a large share of its revenue from taxes on high-income households, such as an additional Medicare payroll tax on those with incomes over $200,000 (single) and $250,000 (married). The law also creates an excise tax on high-cost plans.[5] The costs of the ACA will be offset by an $813 billion increase in revenues, resulting in a $210 billion reduction in the federal deficit.[6] Additionally, provisions are designed to offset the costs of the coverage expansions under the ACA, including one designed to slow the growth of federal health care spending by a reduction in Medicare Advantage plan payments and the development of tools to help reduce fraud and waste in Medicare and Medicaid.

How American Health Care Compares

There are many ways in which countries throughout the world attempt to manage health care. Despite these variations, health care systems tend to follow general patterns and can grouped into four basic systems. In the Beveridge Model, health care is provided and financed by the government through tax payments, as it is in Great Britain, Spain, most of Scandinavia and New Zealand. Second, the Bismarck Model uses a non-profit insurance system that is required to cover all citizens, and usually financed jointly by employers and employees through payroll deduction. This model is found in Germany, France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. Third, the National Health Insurance Model uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. This type of plan controls costs by giving the single payer considerable market power to negotiate lower prices, by limiting the medical services they pay for, or by making patients wait to be treated. The most well-known national health insurance system is found in Canada, but can also be found in Taiwan and South Korea. The final model is the Out-Of-Pocket Model, which basically applies to most developing countries. These countries are usually too impoverished to provide any kind of mass medical care.[7]

The system in the United States has elements of each of these models. It uses the Beveridge Model when treating veterans, and the National Health Insurance Model when treating Americans over the age of 65 on Medicare. For working Americans who get insurance through their employers, the system resembles the Bismarck Model. However, under the ACA, the U.S system will theoretically no longer resemble the Out-Of-Pocket Model, to the extent that individuals comply with the mandate to purchase some type of health insurance.

This brief was written by Utah Foundation Research Director Morgan Lyon Cotti. Contact her at (801) 355-1400 or by email at morgan@utahfoundation.org. *Utah Foundation will publish a more in depth study of the American Care Act later this month.*

[1] Utah Foundation Report 706, "The 2012 Utah Priorities Survey: The Top Issues and Concerns of Utah Voters for the 2012 Election," March 2012.
[2] Utah Foundation Report 708, "The 2012 Utah Priorities Survey of Party Delegates and Voters," April 2012.
[3] "GOP governors name their price on health care law expansion," Politico, July 14, 2012. Available at: http://www.politico.com/news/stories/0712/78499.html#ixzz27WZezQMh
[4] "AP Newsbreak: Medicare's drug coverage gap shrinks," Ricardo Alonso-Zaldivar, Associated Press, November 27, 2011.
[5] "ACA: A Brief Overview of the Law, Implementation, and Legal Challenges," Congressional Research Service, March 2, 2011.
[6] "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Congressional Budget Office, March 30, 2011.
[7] "Health Care Systems: Four Basic Models," PBS, April 15, 2008.