Federal Health Care Reform

January 2011

An Overview

On March 23, 2010, the Patient Protection and Affordable Care Act (hereafter referred to as Affordable Care Act-ACA) was signed into law by President Obama. This comprehensive health reform law will bring about significant changes in the health system. This overview focuses on three of the main components of the law—health insurance coverage, delivery system improvements, and cost containment—with a very brief description of other important provisions related to prevention and public health, workforce, and long term care.

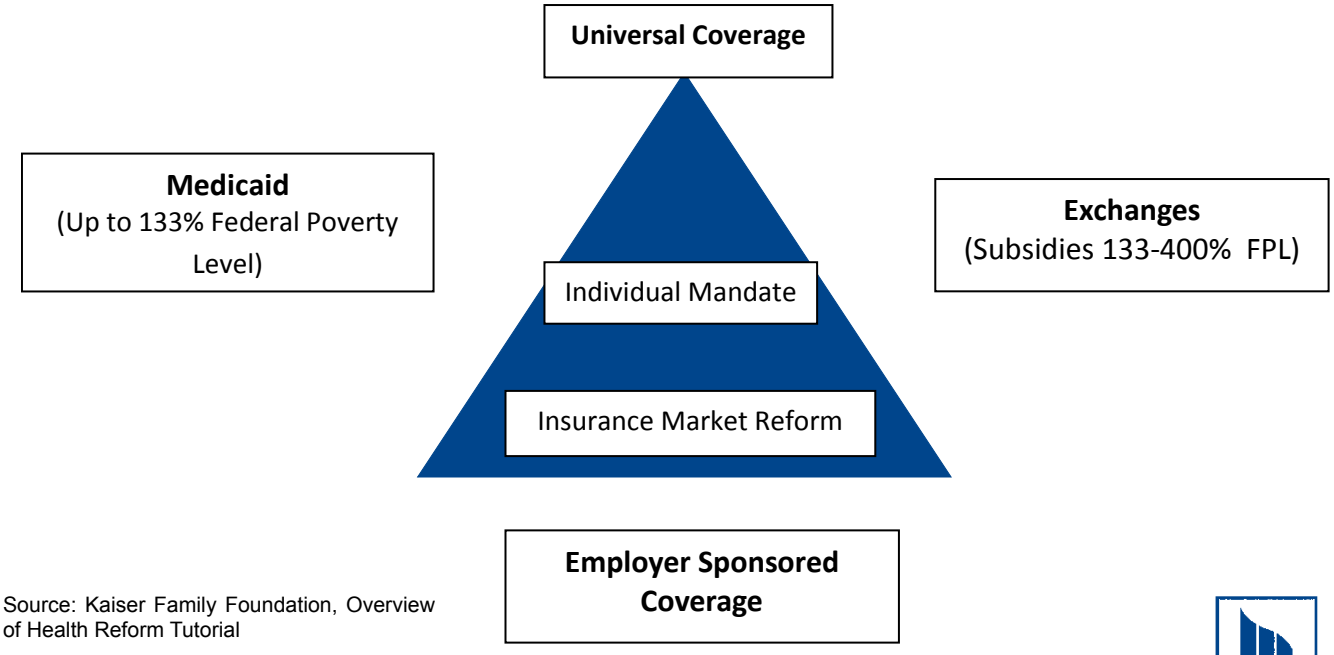
What Does the Affordable Care Act (ACA) Seek to Achieve?

Before delving into the specific components of the law it is important to understand what this legislation seeks to achieve in reform of the health system. While there may be disagreements about the right solutions, most agree on the fundamental problems in our health system: nearly 50 million people in the nation lack health insurance coverage and those with coverage face increasing insurance premiums and plans that may not cover the services they need. There is duplication and inefficiency in health care which translates into poor quality and high costs. And health care costs continue to skyrocket, outpacing increases in inflation as well as workers' wages.

The ACA seeks to address these and other fundamental problems in the health system. The broad goals of the legislation are to extend private and public coverage to an estimated 32 million of the uninsured; improve the affordability and quality of coverage for those who are currently insured; improve access to and the overall quality of care that individuals receive; and reduce the growth in health care costs. The law includes numerous provisions designed to address each of these goals.

Improving and Expanding Insurance Coverage

As illustrated below, the ACA seeks to expand health coverage by expanding the current private insurance market targeting, in particular, individuals and small employers, and filling the insurance gaps in our public programs, especially Medicaid.



Source: Kaiser Family Foundation, Overview of Health Reform Tutorial

Health Insurance Exchanges and Subsidies: A centerpiece of the ACA will be the creation of new health insurance exchanges designed to (1) create better organized markets where individuals and small employers can more effectively shop for coverage and, (2) administer subsidies that will ensure that coverage in the exchanges is affordable to most consumers. Premium subsidies will be available to those with incomes up to 400% of the federal poverty level ($43,300 for an individual and $88,200 for a family of four in 2010). Small businesses (25 or fewer employees) will be eligible for tax credits to help cover part of the cost of health insurance provided to their employees.

Qualified Health Plans: New Health insurance plans offered through the new exchanges must include coverage of essential benefits, including: preventive care (e.g., cancer screenings); prescription drugs; hospitalization and emergency services; maternity and newborn care; mental health and substance abuse treatment; and oral and vision care for children. Individuals and small employers purchasing insurance through the exchanges will have access to four health plan levels which will be tiered to cover 60 to 90 percent of the cost of covered health benefits. Individuals under age 30 will have access to a more affordable catastrophic plan, which will only cover three primary care visits and expensive care (e.g. hospitalization).

Insurance Market Reforms: The law specifies new rules for insurers including:

- Allowing young adults to stay on parents' coverage up to age 26;
- Coverage for certain preventive services without requiring co-payments or deductibles;
- Ending the practice of dropping insurance coverage when a person becomes ill (rescission); and
- Ending the maximum amounts an insurance company will pay per year (annual limits) and for an individual over the course of their life (lifetime limits).

To address the cost of health coverage, the ACA also requires insurance companies to spend a specific portion of premium dollars (80-85%) on health services, limiting how much can be spent on administration or kept as profit (medical loss ratio).

Medicaid Coverage: The ACA also expands public coverage through the Medicaid program, the current safety net health insurance program for the poor. Starting in 2014 Medicaid will cover low-income childless adults and families with incomes up to 133 percent of the federal poverty level ($14,400 for an individual or $29,300 for a family of four in 2010). This expansion is fully funded by the federal government for the first 3 years. Federal funding for the expansion will be stepped down to cover 90 percent of the cost in 2020 and subsequent years.

Individual and Employer Responsibilities: Supporting these enhanced coverage mechanisms are new requirements and incentives/penalties for individuals and employers. Beginning in 2014, most people will be required to have health insurance that meets minimum coverage standards. This controversial provision was included in the law to ensure that the requirement that insurers provide coverage to everyone could work. Without a mandate for coverage, some are likely to choose not to purchase insurance until they get sick (something that is common today). Doing that would drive up premiums for everyone else, making coverage unaffordable for many.

The law also includes new requirements and incentives for employers to offer health coverage to their workers. Beginning in 2014, employers with 50 or more employees that don't offer affordable coverage will be subject to penalties of $2,000 per full-time worker per year, excluding the first 30 workers. The law exempts employers with fewer than 50 employees from the penalties. Very few Maine businesses would be subject to these penalties; according to Maine Department of Labor data over 95% of Maine businesses have fewer than 50 employees. As noted above, the ACA also provides the smallest employers that offer coverage tax credits to offset some of the costs of that coverage. These subsidies began in 2010 and are worth 35 percent of the employer's contribution for coverage of employees.

Other Medicare and Medicaid Changes: And finally the ACA makes other important changes in Medicare and Medicaid to expand access to preventive services (eliminating copayments for preventive care services such as mammograms and annual physicals); improve payment rates for primary care providers; and eliminating over time the gap in Medicare prescription drug coverage (Part D) where enrollees must pay the full cost of any medications (so-called donut hole).

Estimated Impact of Coverage Provisions: The Congressional Budget Office, which provides estimates of the cost and impact of all major legislation, estimates that by 2019 the law will expand coverage to 32 million people. Sixteen million people will be newly covered through the Exchanges and 16 million additional people will be enrolled in Medicaid and the Children's Health Insurance Program. The uninsured rate in 2019 is estimated to be 8% as compared to 19% if health reform had not been implemented (CBO, 2010).

Improving Quality and Reducing Cost

In addition to the provisions focusing on health coverage, the law seeks to make important changes to the health care financing and delivery system to improve health care quality and outcomes and reduce the rate of growth in costs. Some of the cost containment provisions in the health reform law target health care prices, primarily the premiums insurers charge, while others address provider payment methods and the ways in which the health care system is organized that may be contributing to unnecessary care and inefficient delivery of care. Some of the strategies in the legislation include:

- Reducing price increases,
- Supporting the development and testing of new models for delivering health care that promote quality and efficiency,
- Creating incentives for quality and cost performance by changing provider payments.

Controlling costs: With respect to prices, the law requires states to review premium rate requests by insurers to identify excessive or unreasonable premium increases. Starting in 2011, insurers will also be required to spend a certain portion of premium dollars on patient care, as opposed to administrative costs or profits. By requiring that the Health Insurance Exchanges offer standardized plans, the legislation seeks to make it easier for people to comparison shop, which should spur greater choice of health plans and competition and possibly lower premiums.

Other cost controlling changes in provider prices will include changes in Medicare payment policies, including reductions in payments to Medicare managed care plans, known as Medicare Advantage plans, and a slowing of annual payment increases for other providers. The law also targets quality improvement and cost containment by reducing payments to providers for avoidable complications, such as hospital-acquired infections and readmissions.

New Delivery System Models to Improve Quality and Cost Performance: The ACA contains numerous provisions to test several promising delivery system models designed to provide higher quality care more efficiently, including Medical Homes and Accountable Care Organizations. In the case of both of these models the aim is to organize, integrate, and coordinate care to better engage patients, manage and integrate care (especially for patients with on-going health problems such as diabetes and congestive health failure), and thereby improve quality and outcomes and reduce costs. Both models also change how providers are paid to support the delivery system changes and incentivize quality and cost performance.

Maine is already a leader in pursuing these strategies with the multi-payer (including Medicare, Medicaid, and private payers) Maine Patient Center Medical Home Pilot underway for over a year and multiple Accountable Care Organization Pilots in the planning stages under the auspices of the Maine Health Management Coalition.

Health Workforce, Prevention, and Long Term Care

Prevention: The ACA makes a substantial investment in preventive care and wellness activities over the next five years. The National Prevention, Health Promotion and Public Health Council will be established to coordinate federal wellness and public health activities. There are several new grant opportunities and pilot projects for smoking cessation, diabetes prevention, and other health promotion and wellness programs. There is also dedicated funding for prevention and public health activities. And finally, there are incentives for businesses to establish and improve wellness programs. For example, employers may offer employees premium discounts up to 30 percent for participating in a wellness program.

Long Term Health Care and Social Support Services: There are important new initiatives in the ACA designed to expand private coverage to meet long term health care expenses and to strengthen the home and community based care components of existing long term health care and social support programs within Medicaid and other programs. A major goal of the legislation is to expand the availability and affordability of home and community based care and social supports. To this end, the legislation creates a national, voluntary insurance program for buying Community Living Assistance Services and Supports, also called the CLASS program. This program allows individuals with different levels of disabilities (mental and physical) to stay in their home, instead of having to go to a nursing home. The CLASS program will pay around $50 a day for supports like a personal care attendant. After paying into the CLASS program for five years, people will be eligible for this benefit. The program will be self-sustaining and paid for with voluntary payroll deductions. All working adults will automatically be enrolled in the program, unless they choose to opt out.

In addition to the CLASS Act, the legislation contains provisions that provide states greater flexibility and funding to expand home and community based care services available through the Medicaid program, Area Agencies on Aging, and other programs.

Health Workforce: The ACA contain numerous provisions related to the development of the health workforce. The legislation establishes a National Workforce Development Commission and invests over $35 billion over 5 years for training and other initiatives designed to expand primary care, especially in shortage areas. Maine has already received funding for health workforce development under the ACA.

Implementing the ACA

States will have significant responsibilities and challenges in implementing the ACA, especially in the face of stiff political opposition and difficult state budgets. Although many of the key provisions of the legislation will not be implemented until 2014 or later, states and the many other stakeholders will need to be engaged in careful planning to effectively implement them. The National Conference of State Legislators is tracking the planning work of the states and has compiled state planning documents, including the plan developed by the 124th Maine Legislature's Joint Select Committee and the Advisory Council on Health Systems Development (NCSL, 2011). Other technical and informational resources are listed below:

Informational and Technical Resources

National Academy for State Health Policy: http://www.statereforum.org/

National Conference of State Legislatures: http://www.ncsl.org/?TabId=21448

Kaiser Family Foundation: http://kff.org/

National Governors Association: http://www.nga.org

New DHHS consumer website: http://healthcare.gov/

References

Congressional Budget Office. (2010). *Selected CBO Publications Related to Health Care Legislation, 2009–2010.* Washington, DC: CBO.

National Conference of State Legislatures. (2011). *State Reports and Research: Federal Health Reform Implementation.* Washington, DC: NCSL.

Tolbert, Jennifer. (2010, September). *Health Reform: An Overview.* [Tutorial]. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kaiseredu.org/Tutorials-and-Presentations/Health-Reform-Overview.aspx

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