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Federal Health Care Reform: An Overview

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On March 23, 2010, the Patient Protection and Affordable Care Act, also known as “Obamacare” and hereafter referred to as Affordable Care Act (ACA), was signed into law. This broad-reaching health reform law has already, and will continue to bring about significant changes in the health system. This policy brief discusses three of the main components of the law—health insurance coverage, delivery system improvements, and cost containment—and briefly describes other important provisions. The brief highlights some of the provisions of the law that have already been implemented and those where important implementation decisions will have to be made.

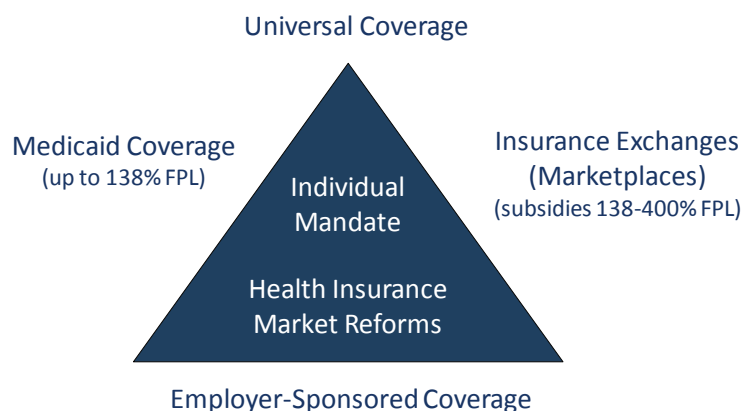
What Does the ACA Seek to Achieve?

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 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 offer affordable coverage for the services they need. There is inefficiency in healthcare which translates into unsustainable increases in healthcare costs for public and private purchasers and citizens. And the quality of healthcare in America is too often lacking. High costs and low quality make the value proposition of our health system very challenging.

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



Source: Kaiser Family Foundation, *Overview of Health Reform Tutorial*.
<http://www.kaiseredu.org/Tutorials-and-Presentations/Health-Reform-Overview.aspx>

Health Insurance Exchanges and Subsidies.

A centerpiece of the ACA will be the creation of new health insurance exchanges (now known as health insurance “marketplaces”) run by the states, the federal government, or jointly. These insurance exchanges are 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 exchange 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.

States have or are grappling with the key decision of whether to develop and run their own exchange, partner with the federal government, or opt for a federal Exchange. Although the deadline for a state-run marketplace has passed, states have until February 15, 2013 to declare their intention to develop a partnership exchange.

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. Under rules that have recently been promulgated, states will be responsible for defining the essential benefit package within broad parameters offered in the rule. 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).

Under the law, states had the option of selecting an essential health benefits plan. The deadline for doing so has passed, however, with Maine (and other states) opting not to submit a plan. The default is that the federal government will use Maine’s largest small-group plan as the benchmark.

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)
- 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).

Each of these new rules has already been implemented.

To address the cost of health coverage, the ACA also requires insurance companies to spend a specific proportion 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.*¹ The ACA also includes a voluntary state expansion of public coverage through the Medicaid program, the current safety net health insurance program for the poor.² Starting in 2014, states will have the option of covering low-income childless adults and families with incomes up to 138 percent of the federal poverty level (\$15,415 for an individual or \$31,809 for a family of four in 2012). 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.

Although there is no deadline for states to decide to adopt the Medicaid expansion, states that defer the decision and decide to expand Medicaid in 2015 or 2016 will lose the benefit of the 100% federal funding starting in 2014.

The ACA also allows states to adopt a Basic Health Plan option designed for Medicaid beneficiaries who are likely to migrate back and forth between Medicaid eligibility and private coverage purchased through the Exchange. It specifically would offer public coverage to individuals who don’t qualify for Medicaid but whose incomes fall below 200% of the federal poverty level, which in 2012 is about \$46,000 for a family of four. To pay for this option, states could draw down 95% of the estimated federal funds that would have gone toward subsidizing the purchase of private insurance by those enrollees through the exchanges.

To date, many states are deciding first whether to expand Medicaid and are awaiting further guidance from the federal government on how the Basic Health Plan will be structured.

Individual and Employer Responsibilities. Supporting 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.

¹ Medicaid (known as MaineCare in Maine) provides coverage for certain categories of people with low incomes. The program is jointly funded and administered by the states and the federal government.

² The June 2012 decision of the United States Supreme Court in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) significantly modified the provisions of the original legislation by requiring that states have the option of expanding Medicaid eligibility.

This controversial provision was included in the law to ensure that insurers required to provide coverage for everyone are not hurt by so-called “free-riders”. Without a mandate for coverage, some would likely choose not to purchase insurance until they get sick (free-riders), thereby driving up premiums for others and making coverage unaffordable for many (something that is common today).

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 cost of that coverage. These subsidies began in 2010 and are worth 35 percent of the employer’s contribution for coverage of employees.

Other Medicare³ and Medicaid Changes. 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 eliminate 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, has recently re-estimated the impact of the ACA’s coverage expansions based on the Supreme Court decision. In 2022, the law will expand coverage to 29 million people. Nineteen million people will be newly covered through the Exchanges and 10 million additional people will be enrolled in Medicaid and the Children’s Health Insurance Program. The uninsured rate in 2022 is estimated to be 11%. This compares to 19% if health reform had not been implemented.⁴

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 and inefficient 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 and penalties 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 are required to spend 80% of premium dollars on patient care, as opposed to administrative costs or profits. In August 2012, the Secretary of Health and Human Services announced that insurers who failed to meet the medical loss ratio (MLR) standards, including CIGNA that offers plans in Maine, will rebate more than \$1.1 billion to 12.8 million policyholders, with an average return of \$151 per household. The law also seeks to control prices by requiring that the insurance exchanges offer standardized plans, thereby making it easier for people to comparison shop, which should spur greater choice of health plans, competition, and possibly lower growth in premiums.

Other strategies to control provider prices and costs 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 eliminating 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 Patient Centered Medical Homes (or Health 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 heart failure), and thereby improve quality and outcomes and reduce

³ Medicare is the national, social insurance program that provides health coverage for all Americans over the age of 65 as well as younger people with permanent disabilities and those with end stage renal disease.

⁴ Congressional Budget Office (March 20, 2010): <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf> See also updated CBO estimates: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>

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 *Patient Centered Medical Home Pilot* (including Medicare, Medicaid, and private payers) underway for three years, three *Accountable Care Organizations* participating in the Medicare “Shared Savings” program (i.e. MaineHealth, Central Maine, and Eastern Maine), and other ACO Pilots in 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 Council has been created to develop a federal prevention strategy and to coordinate federal public health activities. The law creates dedicated funding for prevention and public health activities. Although public health funding has been reduced significantly as a result of federal budget cuts, new public health grant opportunities and pilot projects for smoking cessation, diabetes prevention and other health promotion and wellness programs have been initiated. Maine has already received significant funding through the ACA for public health infrastructure development and performance improvement as well multiple “Community Transformation” grants to build community capacity to address the problems of tobacco use, healthy eating and active living, and chronic disease prevention. And finally, the law contains 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.

A major goal of the legislation is to expand the availability and affordability of home-and-community-based care and social supports. The law 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.

State Implementation of the ACA

States have significant responsibilities and challenges in implementing the ACA. For example, according to the National Conference of State Legislatures, 18 states are developing a state Exchange and six states are planning Exchanges in partnership with the federal government. In the remaining states, including Maine, political opposition to the ACA has led the states to default to a federal Exchange.⁵ States are also developing required coordinated enrollment systems, integrated care initiatives under the ACA’s Health Home and other Medicaid provisions. And finally, 22 states have committed to or are leaning toward implementing the law’s Medicaid expansion. The remaining states, including Maine, are either leaning against or have declared they will not adopt the Medicaid expansions.⁶

The National Conference of State Legislatures, the National Academy for State Health Policy, and other organizations are tracking the implementation of the ACA. These and other informational and technical resources include:

Commonwealth Fund: <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>

Federal Health Reform website: <http://healthcare.gov>

Kaiser Family Foundation: <http://healthreform.kff.org>

National Academy for State Health Policy:
<http://www.statereform.org/>

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

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

Robert Wood Johnson Foundation: Health Reform GPS: <http://www.healthreformgps.org/>

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⁵ National Conference of State Legislatures: <http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx> (Accessed January 29, 2013)

⁶ The Advisory Board Company: <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>