

Understanding Health Reform: A Work in Progress

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On March 23, 2010, President Obama signed HR 3590, the Patient Protection and Affordable Care Act. This legislation, followed closely by amendments to the legislation through HR 4872, the Health Care and Education Reconciliation Act of 2010, is certainly the most sweeping piece of health care legislation since the enactment of Medicare and Medicaid in 1965, and is perhaps the most comprehensive piece of health care legislation in the history of the country. By now, most people have heard or read about provisions of this legislation that will require most people to have health insurance coverage or prohibit insurers from excluding people from coverage based on their pre-existing conditions. But, in reality, this legislation is far more comprehensive and includes provisions that touch all aspects of our health care system.

According to the nonpartisan Congressional Budget Office, the Patient Protection and Affordable Care Act (PPACA)^a will expand coverage to an additional 32 million people by 2019 (92% of all residents or 94% of all legally present non-elderly residents). PPACA does not cover all Americans. Even after the Act is fully implemented, there will still be 23 million uninsured people. The expansion of Medicaid coverage and subsidies to help certain individuals purchase coverage is estimated to cost \$788 billion over the next 10 years (2010-2019).^b While

PPACA includes significant new expenditures on health, it also includes concurrent cuts in health spending and in longer-term cost containment. As a result, the combined health-related provisions in PPACA and in the reconciliation bill are expected to reduce the federal budget deficit by \$124 billion over the next 10 years, and \$1.2 trillion over the next 20 years.¹

There are three critical aspects that must be addressed to achieve meaningful health reform: access, quality, and

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cost. PPACA addresses all three, albeit some issues receive more attention than others. This issue brief attempts to summarize the various aspects of PPACA, recognizing that we may not fully understand all aspects of this legislation for years to come, and describes some of the legislation's primary financing mechanisms. The issue brief includes references to sections of PPACA (HR 3590), as well as

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- a. The formal title of the bill that details most of the changes described here is the Patient Protection and Affordable Care Act. That was then amended and extended by the Health Care and Education Reconciliation Act of 2010. This issue brief will refer to the combination of bills as the "Patient Protection and Affordable Care Act," or PPACA.
- b. The total cost for expanded insurance coverage and subsidies is estimated to be \$938 billion over 10 years. However, PPACA will also generate revenues from the coverage provisions (including the penalty payments paid by uninsured individuals or employers who are not otherwise exempt from purchasing or providing coverage). These revenues are expected to generate \$149 billion over 10 years, leaving a net revenue cost of \$788 billion.

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related sections from the reconciliation bill (HR 4872). In addition, the sidebar at the end of this issue brief includes a listing of other useful summaries of the bills.

PPACA includes new funding to expand coverage, as well as other funding to support other health-related initiatives. If the Act includes direct *appropriations*, it means the funding is immediately available. If the Act includes *authorizations*, it means that Congress authorized spending for that purpose but must appropriate funds for that purpose in a future appropriations bill. Paul Mandsager includes a listing of all the funding provisions in PPACA in his article in this issue of the *Journal* and notes whether funding was appropriated or authorized.

Coverage and Access

Of the three key components of health reform, PPACA concentrates on coverage and access. The legislation focuses on expanding health insurance coverage to non-elderly individuals, as 93% of the elderly (age 65 or older) had Medicare coverage in 2008, while most of the rest had other forms of insurance. Less than 2% of older adults are uninsured.^{2,3}

In contrast, approximately 17% of the non-elderly, or 46 million Americans, were uninsured in 2008. The non-elderly obtain coverage through a variety of sources. Nationally, 62% of the non-elderly have employer-based coverage, 6% have non-group coverage, 15% have Medicaid, 3% have Medicare (for people with disabilities), and 3% have military coverage.³ (These numbers amount to more than 100% because some people have more than one source of insurance coverage.)

In 2008, the percentage of the non-elderly covered through employer-sponsored insurance was somewhat lower in North Carolina than the nation (59% compared to 62% nationally). Approximately 7% of North Carolinians had non-group coverage, 15% had Medicaid, 4% had Medicare, and 6% had military coverage. According to the US Census, approximately 17% of North Carolina's non-elderly population, or 1.4 million people, were uninsured. Recent estimate of the numbers of uninsured, which incorporates the large jump in unemployment rates between 2007-2009.^{c,4} Our more recent estimates suggest that in 2009 there were approximately 52 million uninsured

nationwide, with 1.75 million (21%) uninsured non-elderly North Carolinians.

Expanding Health Insurance Coverage

PPACA includes many provisions to expand health insurance coverage to the uninsured by building on our current multiplatform health insurance structure. It maintains and expands public coverage for low-income people, strengthens employer-based coverage, and makes health insurance more affordable for small businesses and for people who purchase coverage directly. PPACA expands Medicaid to cover more low-income people. In addition, PPACA directs the Secretary of the US Department of Health and Human Services (DHHS) to develop a minimum essential benefits package so that the insurance people buy provides the coverage needed to address most health care needs. The Act also provides subsidies to people with incomes below 400% of the federal poverty level (FPL) who are not covered through a governmental program or their employer, and creates health insurance exchanges (HIEs) where small businesses and individuals can purchase private health insurance coverage. Large employers are required to offer coverage or pay a penalty; however, smaller employers with 50 or fewer employees are exempt from this provision. In addition, the Act makes a number of essential changes to the insurance industry and expands access to coverage for many with pre-existing health conditions. With these changes, most people in this country will be required to either purchase health insurance coverage or pay a tax to the federal government.

Public Health Insurance Coverage for Low-Income Families and Children

Effective 2014, PPACA expands the Medicaid program to cover all non-elderly low-income citizens and many lawfully permanent residents with incomes below 133% FPL (see Table 1).⁵ The new law removes all of the categorical restrictions that in the past excluded many low-income people (primarily childless adults) from coverage.^d For most people, eligibility will be determined solely based on income and whether the person is a citizen or has been a lawful permanent resident residing in the United States for five years or more. Undocumented immigrants continue to be

c. North Carolina's unemployment rates increased from 4.7% in January 2007 to 9.7% in January 2009.

d. Medicaid is an entitlement program that is funded jointly between the federal and state governments. The federal government sets broad program rules and gives the states flexibility to design their programs within those broad rules. Each state's Medicaid eligibility rules are different. In the past, Congress limited Medicaid coverage to certain types of low-income people (i.e., children under age 21, the parents of dependent children, pregnant women, people who were 65 or older, or people who were disabled). States had considerable latitude in setting income and resource eligibility limits. Childless adults, who were not yet 65 or disabled, were not eligible for Medicaid in most states, regardless of income. Because of the categorical, income, and resource restrictions, Medicaid only covered, on average, 42% of all low-income people in the country (2008) or 40.7% of all low-income people in North Carolina (2007-2008). (The Henry J. Kaiser Family Foundation. Medicaid coverage rates for the nonelderly by federal poverty level (FPL), states (2007-2008), US (2008). Statehealthfacts.org website. <http://www.statehealthfacts.org/comparetable.jsp?ind=161&cat=3>. Accessed April 26, 2010.)

Table 1.
Medicaid Income Limits
(133% Federal Poverty Level)

Family Size	133% FPL/year (2009)
1	\$14,404
2	\$19,378
3	\$24,352
4	\$29,327
Each additional person	\$3,740

Source: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pgs. 4199–4201.

ineligible for regular Medicaid coverage. Low-income adults who become eligible as a result of PPACA will be entitled to the essential benefits package (defined in a later section of this issue brief) and not full Medicaid coverage.

The federal government will pay 100% of the costs for the new eligibles for the first three years to help offset the new costs that states will incur due to this expansion. This federal match rate phases down to 90% over time (until 2020). The NCIOM worked with Mark Holmes at the Department of Health Policy and Management, Gillings School of Global Public Health, to develop estimates of the numbers of people who will be eligible for, and enroll in, Medicaid beginning in 2014 (see *Running the Numbers* in this issue of the *Journal*). Dr. Holmes estimates that that in 2014 there will be approximately 340,000 new people eligible for Medicaid in North Carolina as a result of this expansion. Of these, approximately 257,000 will enroll. In addition, Dr. Holmes estimates that there are already approximately 320,000 people who are currently eligible for but not enrolled in Medicaid. Of these, approximately 167,000 will enroll. The federal government will pay its regular match rate (approximately 64%) for individuals who enroll as a result of the new law but who were already eligible for Medicaid under existing laws.^e

PPACA also includes other provisions that should help expand access to services for low-income people. States must increase the Medicaid reimbursement rate for primary care procedures to 100% of the Medicare rates beginning in 2013.^f North Carolina already pays 95% of Medicare rates for primary care services under Medicaid; however many states pay primary care providers far less, which has contributed to access barriers.⁶

Low-income children will continue to receive Medicaid or NC Health Choice (North Carolina's Children's Health Insurance Program, or CHIP), depending on their age and income, up until 2019. Currently, children between birth and age 5 are eligible for Medicaid if their family income is less than 200% FPL. Children between the ages of 6-18 are eligible for Medicaid with incomes up to 100% FPL. Those with incomes between 100%-200% FPL are eligible for NC Health Choice. Effective January 1, 2014, children of all ages with incomes below 133% FPL will be transitioned into Medicaid. Children with incomes between 133%-200% FPL will remain in NC Health Choice until October 1, 2019.⁷ Thereafter, children will gain coverage through their parents' employer-sponsored insurance or, if not available, through the HIE (described more fully later in this issue brief).

PPACA also includes many provisions to streamline and simplify the Medicaid and CHIP enrollment and reenrollment processes. For example, the state Medicaid agency must allow people to apply for Medicaid through the internet, screen people who are ineligible for Medicaid or NC Health Choice for the subsidies offered through the HIEs, and conduct outreach to vulnerable populations.⁸ States also are permitted to give hospitals the authority to make presumptive eligibility determinations for all Medicaid eligible populations, thereby facilitating enrollment for people who present at the hospital.⁹

Private Coverage

Congress recognized that most people receive their insurance coverage from employers and then directly from insurers. Thus, at the same time that the legislation expands Medicaid to make health insurance affordable to lower-income people, the Act also expands access to affordable coverage in the private market. PPACA directs the DHHS Secretary to establish a minimum essential benefits package to ensure that adequate coverage is available in the private market. States will be directed to create HIEs where individuals and small businesses can purchase coverage. Subsidies will be available to help many people purchase coverage if they are buying health insurance on their own or if they do not have access to affordable coverage through their employers.

The bill does not require individuals to change insurance coverage if they are satisfied with the health insurance coverage they had on March 23, 2010 (either through their employer or in the individual market). These existing plans

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- e. The federal match rate for North Carolina was 64.05% in fiscal year (FY) 2008. The match rate was enhanced in FY 2009 and FY 2010 because of the downturn in the economy (to 73.55% and 74.98%, respectively); however, the enhanced match rate is scheduled to expire December 31, 2010 (or may be extended to June 30, 2011, with legislation currently pending in Congress). Thereafter, the federal medical assistance percentage (FMAP) rate will be reduced to its regular level.
- f. Primary care services include evaluation and management services that are procedure codes for services designated as Evaluation and Management in the Healthcare Common Procedure Coding System and services related to immunization administration (Sec. 2303 of PPACA, as amended by Sec. 1202 of Reconciliation).

Health Reform:

Provisions for Immediate Implementation

Catherine E. Liao, MSPH

The Patient Protection and Affordable Care Act (PPACA) will be phased in over the next four years (2010-2014). However, some of the provisions are scheduled to take effect within the next year. The following is a short description of those provisions that will go into effect over the next 18 months. This summary does not include information about grant opportunities provided in the bill. (See Paul Mandsager's article for more information about new grant funding available under PPACA.)

Information presented here was obtained from North Carolina Institute of Medicine (NCIOM) staff analysis of the legislation and from the Kaiser Family Foundation timetable.¹ More information on federal health reform is available on the NCIOM website at <http://www.nciom.org/data/healthreform.php>.

2010

- Small businesses with up to 25 full-time employees with average annual wages of up to \$50,000 are eligible for sliding-scale tax credits to help offset the costs of providing health insurance coverage to employees. To qualify, employers must pay at least 50% of the premium costs. The tax credit is effective January 1, 2010.²
- Medicare beneficiaries who reach the Part D prescription drug donut hole receive a \$250 rebate. This provision applies to individuals "who as of the last day of a calendar quarter in 2010 has incurred costs for covered Part D drugs so that the individual has exceeded the initial coverage limit."³
- Insurers must submit proposed premium increases to state Commissioners of Insurance for review to determine reasonableness. This provision takes effect upon enactment and applies to the 2010 plan year.⁴
- Employers with 50 or more employees must provide break time and a place for breastfeeding mothers to express milk, effective upon enactment.⁵

Effective July 1, 2010

- \$5 billion in new funding is available to establish a high risk pool for uninsured people with pre-existing conditions.⁶ (See Michael Keough's sidebar for more information about how this will operate in North Carolina.)
- \$5 billion in new funding is available to create a temporary reinsurance program to help offset some of the claims costs for employers who provide health insurance coverage to early retirees ages 55-64.⁷
- The Secretary of the US Department of Health and Human Services creates a website to help consumers identify affordable health insurance in each state.⁸
- Tanning salons pay an extra 10% tax on indoor tanning services.⁹
- Some time before March 2011, the federal government will provide grants to states to begin planning for the creation of state health insurance exchanges.¹⁰
- National advisory groups are created to develop strategies for health workforce, quality improvement, prevention, and comparative effectiveness research.¹¹

Effective for Health Plans Issued After September 23, 2010

- Insurers are prohibited from imposing lifetime caps on the dollar value of essential health benefits for any participant or beneficiary.¹²
- Insurers are prohibited from dropping coverage of people when they get sick.¹³
- Insurers are prohibited from denying coverage to children under age 19 with pre-existing conditions or imposing pre-existing condition exclusions based on health status.¹³
- New private plans must cover preventive services and not charge cost sharing. Preventive services include clinical services that have received a rating of "A" or "B" from the US Preventive Services Task Force; immunizations recommended by the Advisory Committee

are considered to be "grandfathered" plans and do not need to meet all the same insurance requirements as newly created health plans.⁸ While many people will maintain their existing coverage, others will be able to purchase insurance through newly created HIEs. PPACA also reforms the insurance industry by eliminating many of the insurance practices that have prevented individuals with pre-existing conditions from obtaining affordable coverage.

Essential Benefits Package

PPACA directs the DHHS Secretary to develop an essential health care benefits package that includes a comprehensive set of services.¹⁰ All qualified health plans offered through the HIE must provide at least the essential benefits. (The essential health benefits provision does not apply to grandfathered plans or to Employment Retirement Income Security Act (ERISA) plans.) The Act requires the DHHS Secretary to include certain core services in the

g. The bill does not specify what types of changes can be made to an existing health insurance plan and still be considered a "grandfathered" plan. Therefore, the DHHS Secretary will need to promulgate rules to clarify, for example, whether a health insurance plan will be considered to be grandfathered if an employer or insurer changes the cost sharing or services covered under the plan. (Fernandez B. *Grandfathered Health Plans Under PPACA* (P.L. 111-148). Washington, DC: Congressional Research Service; 2010. Report R41166. <http://www.ncsl.org/documents/health/GrandfatheredPlans.pdf>. Accessed May 14, 2010.)

on Immunization Practices; and evidence-informed preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women.¹⁴

- Young people up to the age of 26 years can be covered by their parents' health plan.¹³
- Insurers are required to spend at least 80% (individual and small group) or 85% (large group market) of premium dollars on medical services.¹⁵ (Note: This provision does not apply to self-funded or ERISA plans.)
- Enrollees can select any primary care provider from participating providers, cannot be charged more for out-of-network emergency services, and can self-refer to an OB-GYN.¹⁶

2011

- Medicare beneficiaries with Part D prescription drug plans receive a 50% discount on brand-name drugs and biologics in the donut hole.³
- Medicare is expanded to cover more screening and preventive services, including an initial preventive physical exam, with no cost sharing.¹⁷
- Primary care physicians and general surgeons practicing in underserved areas receive a 10% bonus payment from Medicare, effective 2011 through 2015.¹⁸

- Insurers are required to provide a rebate to enrollees if the health insurance issuer spends less than 80% (individual and small group) or 85% (large group market) of premium dollars on medical services.¹⁶ (Note: This provision does not apply to self-funded or ERISA plans.)
- The Secretary of the US Department of Health and Human Services creates a new voluntary, public long-term care insurance program, called Community Living Assistance Services and Supports (CLASS).¹⁹
- Payments to Medicare Advantage plans are frozen at 2010 levels and reduced annually thereafter.²⁰
- Pharmaceutical companies pay new annual fees based on branded prescription drug sales.²¹
- Chain restaurants and vending machines must provide nutritional content of standard menu and other food items. Not later than one year after the date of enactment, the Secretary of the US Department of Health and Human Services will promulgate regulations to carry out this provision.²²

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2. Secs. 1421, 10105 of PPACA.
3. Sec. 3301 of PPACA, as amended by Sec. 1101 of Reconciliation.
4. Sec. 1003 of PPACA.
5. Sec. 4207 of PPACA.
6. Sec. 1101 of PPACA.
7. Secs. 1102, 10102 of PPACA.
8. Sec. 1103 of PPACA.
9. Sec. 10907 of PPACA.
10. Sec. 1311 of PPACA.
11. Secs. 3011-3012, 4001, 4003, 5101, 6301, 10501 of PPACA.
12. Sec. 1001 of PPACA, as amended by Sec. 2301 of Reconciliation.
13. Secs. 1001, 1201, 10103(e) of PPACA.
14. Sec. 1001 of PPACA.
15. Secs. 1001, 10101 of PPACA.
16. Sec. 10101 of PPACA.
17. Sec. 4104 of PPACA.
18. Sec. 5501 of PPACA.
19. Secs. 8001-8002 of PPACA.
20. Secs. 1102-1103 of Reconciliation.
21. Sec. 9008 of PPACA, as amended by Sec. 1404 of Reconciliation.
22. Sec. 4205 of PPACA.

essential benefits package, including hospital services; professional services; prescription drugs; rehabilitative and habilitation services; mental health and substance abuse services in parity with other benefits; preventive services and vaccines; and maternity care. In addition, for children under age 21, the essential benefits package also must include well-baby, well-child, oral health, vision, and hearing services.^{10,11} Further, the plan must cover preventive services with no cost sharing (as described more fully later).¹²

Qualified health plans offered through the HIE must offer four levels of benefits.¹³ The lowest cost plan—the “bronze” plan—must ensure that the plan covers 60% of the actuarial costs of the essential health benefits. “Silver” plans must cover 70%, “gold” plans must cover 80%, and “platinum”

plans must cover 90% of the benefit costs. In general, the higher the level of plan, the more a person will pay in premiums, but the less they will pay in out-of-pocket costs.

Health Insurance Exchanges

States will be required to create two HIEs—one for individuals (American Health Benefit Exchange) and one for small businesses with 100 or fewer employees (Small Business Health Options, or SHOP)—although states have the option of merging these two exchanges into one.¹⁴ These HIEs are intended to make it easier for individuals and small businesses to purchase coverage. The HIEs are required to offer standardized information to help consumers choose between plans based on quality and costs; offer “navigators”

to provide information to the public about health plan choices and assistance with enrollment; determine eligibility for the health insurance premium tax credit (subsidy, discussed more fully below); and certify if someone meets the exemption from the health insurance mandate. HIEs also must certify qualified health plans to let them offer their insurance in the exchange. In addition, exchanges will offer at least two multistate or nationwide qualified health plans, at least one of which will be nonprofit.¹⁵

Notably, the Act envisions a “no-wrong door” approach to health insurance. People who first seek coverage through the HIE will be screened for eligibility for Medicaid or NC Health Choice and enrolled directly into those programs if eligible. Conversely, if a person applies for Medicaid or NC Health Choice at a local department of social services and is found to be ineligible but meets the requirements for the premium subsidy, then they should be enrolled directly into the subsidy program.¹⁶

Employer-Based Coverage

As noted earlier, most people obtain coverage through their employer. PPACA requires large employers (with more than 50 employees) to either offer coverage to their employees and dependents or pay a penalty.¹⁷ Employers with more than 50 employees and that do not offer affordable coverage that meets the statutory minimum requirements will be required to pay \$2,000 for each full-time employee, excluding the first 30 employees.

Notably, the Act does not require employers to pay any share of the premium for their employees or dependents. However, employers can be penalized if any of their employees qualify for and receive a premium tax credit in the HIE. As described later in this issue brief, individuals with access to employer-based coverage are generally ineligible for premium subsidies unless: (1) the coverage does not provide coverage for at least 60% of the actuarial cost of the health care package, or (2) the employee's share of the premium exceeds 9.5% of his or her annual income.¹⁸ If one of these situations occurs *and* the employee has a family income less than 400% FPL, then he or she is eligible for a subsidy in the exchange. Employers are required to pay \$3,000/year for each full-time employee who receives a subsidy, even if the employer otherwise offers coverage.^{h,17}

Employers who offer and pay for coverage for their employees also are required to provide certain employees with a “free choice” voucher.¹⁹ The voucher is equal to the amount that the employer would have contributed for the individual and his/her dependents if the person chose to enroll in the employer-sponsored insurance. Employees are eligible for this voucher if their share of the premium cost is

between 8%-9.8% of their household income. In this event, the employee can choose to take the voucher and purchase coverage in the HIE or can opt to enroll in the insurance offered by the employer. Employers who provide a free choice voucher do not pay a penalty for individuals who seek coverage through the exchange.

Small businesses with fewer than 50 full-time employees are exempt from the requirement to offer coverage.¹⁷ However, the bill provides a tax credit for certain small employers to help them pay for coverage for their employees.^{i,20} To qualify, a business must have 25 or fewer employees and average annual wages of less than \$50,000. The small business tax credit will be implemented in two phases:

- Phase I (2010-2013): Small, for-profit businesses will be eligible for a tax credit of up to 35% if the employer provides coverage and pays at least 50% of the total premium cost. The full tax credit is available to small businesses with 10 or fewer employees and average annual wages of less than \$25,000. The credit is phased out for employers with up to 25 employees or for those firms with higher average wages (not to exceed \$50,000/year). Nonprofit organizations are also eligible for a sliding scale payroll tax credit; however, the maximum tax credit is 25% for nonprofits.
- Phase II (2014-on): Small businesses are eligible for a 50% tax credit for up to two years. Aside from the increased maximum amount of tax credit, the program rules are similar to those in Phase I, with the maximum credit available to small businesses with 10 or fewer employees with an average annual wage of \$25,000 or less. Nonprofits will be eligible for a maximum tax credit of up to 35%.

Individual Responsibility

A lot of the criticism of the bill has focused on the individual “mandate.” In this issue of the *Journal*, Barak Richman discusses the legal challenges that have been filed to prevent implementation of the bill based on this mandate. In reality, the Act does not require anyone to purchase insurance coverage. However, most citizens and legal immigrants will have to pay a financial penalty starting in 2014 if they do not have health insurance that meets the requirements for minimum essential benefits.²¹ While this provision applies to many individuals, there are certain groups who are exempt from the individual mandate, including but not limited to those who are not required to pay taxes, those who have a religious exemption, and individuals for whom the lowest cost plan exceeds 8% of their annual income.²²

h. The maximum that an employer will have to pay is the equivalent of \$2,000 per full-time employee (the same amount the employer would have had to pay if the employer did not offer coverage).

i. More information about the small business tax credit is available at <http://www.irs.gov/newsroom/article/0,,id=220839,00.html>.

Individuals can purchase insurance coverage either inside or outside the exchange.²³ Further, individuals can maintain existing coverage if they were enrolled in a policy as of March 23, 2010.²⁴ These latter plans are considered to be “grandfathered” plans and are not required to follow all the same requirements as new plans offered in the individual or non-group market.

The amount of the penalty will increase over time. In 2014, an individual must pay \$95/person or 1% of their taxable income (whichever is greater). When the penalties are fully phased in (2016), an individual will have to pay \$695 per individual or 2.5% of income (whichever is greater). Families with three or more people will pay the greater of the percentage of income or three times the penalty amount.²⁵

Premium Subsidies

Low- and moderate-income individuals who do not have access to employer-sponsored insurance, and who are not eligible for publicly subsidized insurance (including Medicaid, NC Health Choice, Medicare, or TRICARE), may be eligible for premium subsidies. PPACA provides refundable and advanceable premium credits to individuals with incomes up to 400% FPL on a sliding scale basis.¹⁸ The subsidy is based on the second lowest cost silver plan. To qualify, an individual

must verify his or her income, citizenship, and immigration status. Employees also are eligible for the premium coverage if they are offered coverage by an employer that does not meet the requirements for minimum essential coverage (i.e., the plan does not cover 60% of the costs of the benefits) or if the premium exceeds 9.5% of the employee’s annual income.

The sliding scale subsidies cover the costs of premiums, cost sharing (i.e., copayments, coinsurance), and out-of-pocket cost sharing limits.¹⁸ Table 2 shows the available subsidies.

To demonstrate how this would work, assume the Smith family has four people and a family income that equals \$33,075/year (150% FPL in 2009). They want to purchase a family policy with a premium cost of \$12,300/year (the approximate average amount of family premiums in North Carolina in 2008).²⁶ Let’s assume the plan has an 80% medical loss ratio (which means that 80% of the premium costs are used to cover medical expenses, and the remaining 20% are for administrative expenses and profits). Thus, of the \$12,300 in premiums, \$9,840 would be spent, on average, for medical expenses. Let’s also assume that this insurance policy met the requirements for a silver level plan (which means that the policy covers, on average, 70% of a family’s health care costs covered by the plan). That means that the total average health care costs for this family plan would be

Table 2.
Premium, Out-of-Pocket Cost Sharing, and Out-of-Pocket Limits for People Eligible for Subsidies

Individual or family income*	Maximum individual or family premiums	Out-of-pocket cost sharing ^a government pays (individual or family pays)	Out-of-pocket cost sharing limits per year ^b (individual/family)
< 133% FPL	2% of income	94% (6%)	\$1,983 / \$3,967 (one-third HSA amount)
133% up to 150% FPL	3%-4%	94% (6%)	\$1,983 / \$3,967
150% up to 200% FPL	4%-6.3%	87% (13%)	\$1,983 / \$3,967
200% up to 250% FPL	6.3%-8.05%	73% (27%)	\$2,975 / \$5,950 (one-half HSA amount)
250% up to 300% FPL	8.05%-9.5%	70% (30%)	\$2,975 / \$5,950
300% up to 400% FPL	9.5%	70% (30%)	\$3,967 / \$7,934 (two-thirds HSA amount)

a. Out-of-pocket costs include deductibles, coinsurance, and copays.

b. Maximum out-of-pocket limit includes the amount spent on deductibles, coinsurance, and copays. Premiums are not included in the out-of-pocket limits. The Health Savings Account (HSA) limits are currently set at \$5,950 per individual and \$11,900 per family (2010 and 2011); however this amount will increase over time.

* Any person or family whose household income level is equal to the upper threshold of the FPL range is considered part of that income tier. Thus, for example, a person whose income is exactly 150% FPL will fall into the 133% up to 150% FPL income tier.

Source: Secs. 1401 and 1402 of PPACA, as amended by Sec. 1001. (The Henry J. Kaiser Family Foundation. *Summary of New Health Reform Law*. The Henry J. Kaiser Family Foundation website. <http://www.kff.org/healthreform/upload/8061.pdf>. Publication no. 8061. Published April 21, 2010. Accessed May 28, 2010.)

j. The 2009 federal poverty levels are: \$10,830/year for an individual or \$22,050/year for a family of four. Thus, 400% of the federal poverty level is \$43,320/year for an individual or \$88,200 for a family of four.

approximately \$14,057/year: \$9,840 would be covered by the premium, and the other \$4,217 would be passed along to the family through cost sharing expenses (deductible, copayments, and coinsurance). Because of the premium subsidy, the Smith family is required to pay \$1,323/year (\$110.25/month) or 4% of their income in premiums (rather than the full \$12,300). Assuming the Smith family spends the average amount on health care that year (\$14,057), they would pay an additional \$843 in out-of-pocket costs (6% of the \$14,057). If, however, they incur more than an average amount of health care costs, their total out-of-pocket costs for covered benefits (excluding the premium) would be capped at \$3,967/year for the family.^k Once the family reaches this out-of-pocket limit, the plan would begin to pay 100% of all covered health care costs. If the Smiths were earning \$66,150/year (300% FPL), they would be required to pay 9.5% of their income, or \$6,284/year in premiums (\$524/month). If they incur average health care costs, they would also pay \$4,217/year in out-of-pocket health care expenses (or up to \$5,950 if they incurred catastrophic health care costs). Table 3 provides the premiums and out-of-pocket spending amounts for individuals and families with different incomes (as a percentage of FPL). Note that,

for purposes of the example, we assumed that the second lowest cost silver plan had a premium cost of \$4,460/year for an individual^l or \$12,300 for a family (the amount North Carolinians paid, on average, for employer-sponsored health insurance in 2008).

Congress enacted two additional provisions to ensure that health plans are affordable to young adults and children. First, PPACA includes an option for catastrophic coverage that is limited to people younger than age 30 or to those who are exempt from purchasing coverage because the lowest cost plan exceeds 8% of their annual income.²⁷ Catastrophic plans have lower cost premiums because the insurer does not begin to pay for most covered services until the person's health care costs exceed a high deductible level (currently set at \$5,950 for an individual or \$11,900 for a family).^m Second, insurers that offer qualified health plans in the exchange must also offer similar plans to children only.²⁸

Insurance Reforms

In the past, many health insurers excluded people in the non-group market from insurance coverage if they had pre-existing health problems. These practices were implemented, at least in part, to reduce adverse selection.

Table 3.
Premium and Out-of-Pocket Spending for Individuals and Families at Different Incomes

	Average total health care cost	Total yearly premium costs without subsidy	Yearly premium costs with subsidy (% of income)	Average out-of-pocket costs (cost sharing) without subsidy	Out-of-pocket cost sharing with subsidy (% of income)	Maximum out-of-pocket limit without subsidy	Maximum out-of-pocket limit with subsidy
150% FPL							
Individual (\$16,245/yr)	\$5,097	\$4,460	\$650 (4%)	\$1,529	\$306 (6%)	\$5,950	\$1,983
Family of four (\$33,075/yr)	\$14,057	\$12,300	\$1,323 (4%)	\$4,217	\$843 (6%)	\$11,900	\$3,967
300% FPL							
Individual (\$32,490/yr)	\$5,097	\$4,460	\$3,087 (9.5%)	\$1,529	\$1,529 (30%)	\$5,950	\$2,975
Family of four (\$66,150/yr)	\$14,057	\$12,300	\$6,284 (9.5%)	\$4,217	\$4,217 (30%)	\$11,900	\$5,950

Source: Average individual premium in North Carolina (2008). MEPS. Table II.C.I. (2008). http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiic1.pdf.

Average family premium in North Carolina (2008). MEPS. Table II.D.1 (2008). http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiid1.pdf.

- k. This assumes that the insurer sets the maximum allowable out-of-pocket cost limit. An insurer could offer a plan with a lower out-of-pocket cost limit, in which case, the family's out-of-pocket costs would be capped at a lower limit.
- l. For purposes of this example, we assumed that \$3,568 of the individual premium (\$4,460) would be spent on medical expenses. Assuming that this plan met the requirements for a silver plan, the total actuarial value of the plan would be \$5,097.
- m. The high deductible is tied to the HSA deductibles. PPACA exempts preventive services and three primary care visits from the deductible (in other words, the catastrophic plan will cover these costs before the person meets the deductible).

Without pre-existing condition exclusions, people could wait until they were seriously ill before purchasing insurance coverage. This would lead to fewer healthy people in the insurance pool, driving up the health care costs for those who remained in the pool (further discouraging healthy people from purchasing insurance). Insurers have used pre-existing condition exclusions to discourage people from waiting until they were sick to purchase coverage. In addition, insurers typically charged people more based on their health status and age. This practice made coverage more affordable to people who are younger and healthier but much more expensive for those who were older or sick. To further control the costs of health care premiums, insurers often imposed annual or lifetime limits on the amount of money they would pay out on behalf of an individual during the year (or during the person's lifetime).

PPACA changes these practices. Insurers will no longer be able to deny coverage to children under age 19 with pre-existing conditions, beginning with plans that begin after September 23, 2010. In addition, PPACA prohibits plans from imposing lifetime caps, restricts the use of annual caps for essential benefits, and extends coverage to young adults up to age 26 under their parents' coverage.^{n,29} Insurers are also prohibited from dropping coverage for people when they get sick, a practice that appears to have been more common in other states than in North Carolina. PPACA also appropriated \$5 billion in funding to help support a high risk pool for people with pre-existing conditions.³⁰ In this issue of the *Journal*, Michael Keough discusses plans for implementing the federal high risk pool in North Carolina as well as the differences between the state high risk pool (Inclusive Health) and the newly-created federal high risk pool.

When the bill is fully implemented (January 1, 2014), insurers will no longer be able to exclude people or groups, or set premium costs, based on a person's pre-existing conditions or use of health services.³¹ Further, insurers can only vary premiums based on age (3:1 differential),^o geographic area, family composition, and tobacco use (limited to 1.5:1) in the individual and small group market. Insurers must submit their premium rate increases to the Department of Insurance for review and/or approval if allowed under state law.³² Further, insurers may not impose annual or lifetime limits.³³ The North Carolina Department of Insurance will be primarily responsible for enforcing most of these new provisions. Insurance Commissioner Wayne

Goodwin discusses the new insurance provisions and the creation of a state HIE in his commentary in this issue of the *Journal*.

Other Coverage Provisions

Medicare

PPACA does not change eligibility for Medicare. However, it does expand the services that are offered and changes some of the cost sharing provisions. Effective January 1, 2011, Medicare beneficiaries will be eligible for a personalized prevention plan without cost sharing. The plan will include, but not be limited to, clinical preventive services recommended by the US Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices, with no cost sharing.³⁴ Medicare will also begin to cover an annual wellness visit as part of a personalized prevention plan (effective January 1, 2011). Further, the Act provides some additional protections for people enrolled in a Medicare Advantage plan. Effective January 1, 2011, Medicare Advantage plans cannot charge more in cost sharing (copayments, deductibles, or coinsurance) for Medicare-covered services than is allowed under traditional Medicare.^{p,35}

In addition, Medicare will begin phasing out the Part D prescription drug "donut hole." The donut hole is a gap in Medicare prescription drug coverage in which Medicare Part D enrollees, after reaching an initial coverage limit, must pay 100% of total drug costs before catastrophic coverage begins. Effective this year, Medicare recipients who reach the donut hole will receive a \$250 rebate for the costs of medications purchased in the coverage gap.³⁶ The donut hole will be phased out between now and 2020. In 2020, Medicare recipients will be required to pay 25% of the costs of their medications (similar to what they currently pay initially for drug coverage) until they reach the catastrophic level, at which point Medicare will pay 95%. Bob Jackson describes the Medicare provisions in more detail in his commentary in this issue of the *Journal*.

Long-Term Care

Historically, private health insurance has not covered long-term care services. Long-term care services include services provided by nursing homes, intermediate care facilities for people with intellectual and/or other developmental disabilities, or home- and community-based

n. These provisions are effective for health plan years that begin after September 23, 2010.

o. The compression of the rating bands based on age could have the effect of reducing premiums for older adults (ages 55-64), but increasing the rates for younger adults (ages 18-30). However, with all the other changes in PPACA—including the larger risk pools—it is uncertain whether rates will increase for younger adults. PPACA does allow younger adults under age 30 to purchase catastrophic plans. These plans should have lower premium rates than the bronze, silver, gold, or platinum plans offered through the HIE.

p. Approximately 17% of North Carolina Medicare beneficiaries were enrolled in Medicare Advantage plans in 2009. This compares to a national average of 22.5%. (The Henry J. Kaiser Family Foundation. Medicare Advantage (MA) plan penetration, 2009. Statehealthfacts.org website. <http://www.statehealthfacts.org/comparetable.jsp?ind=329&cat=6>. Accessed April 28, 2010.)

services for people who need assistance with activities of daily living.^q In the past, individuals who wanted long-term care insurance had to purchase a separate policy for those benefits. Low-income people and other individuals with more resources could qualify for Medicaid to cover long-term care services only after exhausting most of their own income and resources.

PPACA begins to address this problem. Congress created a new public long-term care insurance program effective January 1, 2011 to help with home- and community-based services, called the Community Living Assistance Services and Supports (CLASS).³⁷ CLASS will be financed through a payroll deduction. Everyone will be enrolled automatically; those who do not want this coverage can opt-out. The amount of a person's payroll deduction will be based on his or her age when they first enroll.^r People are vested once they have paid into CLASS for five years. To receive benefits, a person must have difficulties with at least two or three activities of daily living, need substantial supervision due to cognitive impairments, or have a similar level of functional limitations. CLASS will pay cash benefits of not less than \$50/day to purchase non-medical services and supports. The actual amount of the services will vary based on functional ability.

In addition to the CLASS program, PPACA also gives states new options and financial incentives to expand home- and community-based services through the Medicaid program. Effective October 1, 2011, states can implement the Community First Choice Option.³⁸ This Medicaid optional program provides home- and community-based attendant services and supports to individuals who would otherwise need institutional care if they have incomes that do not exceed 150% FPL (\$16,245/year for an individual or \$21,855/year for a couple in 2009). Funding is only available to support people in a home or community setting (not an institutional setting). The state receives an enhanced federal match rate if they adopt this option. States have additional Medicaid options to expand home- and community-based services to frail older adults and people with disabilities to help them remain in the community.^{s,39}

Safety Net

Most of the coverage expansion will occur in 2014. However, there are between 47 million (2009 US Census estimates) and 52 million (NCIOM estimates) people who lack insurance coverage nationwide. What kinds of coverage

will these people have while the benefit expansion phases in?

To try to begin expanding access to care, Congress authorized new funding for safety net providers. These are health care providers with a mission or legal obligation to serve uninsured and other underserved populations. Last year, as part of the American Recovery and Reinvestment Act (ARRA), Congress appropriated \$2 billion to expand federally qualified health centers (FQHCs, also known as community and migrant health centers).⁴⁰ Most of the funding in ARRA was for construction, repairs, and renovation; new equipment; and to purchase health information technology (HIT). As part of PPACA, Congress appropriated a total of \$9.5 billion over five years (\$1 billion in FY 2011 increasing to \$3.6 billion by FY 2015) in operational costs to support expansion of FQHCs.⁴¹ In addition, Congress appropriated another \$1.5 billion over five years for construction and renovation of FQHCs and made several other changes to enhance the financial viability of these safety net providers. In his commentary, E. Benjamin Money discusses these new provisions.

In addition, PPACA appropriated \$50 million in each year (FY 2010-2013) to support capital and construction of school-based health centers. Other funds are authorized (but not appropriated) to support operational costs.⁴² In 2009, North Carolina had 56 school-based or school-linked health centers in 26 Local Education Agencies serving approximately 28,000 students.⁴³ To receive the new federal funding, school-based health centers must provide comprehensive primary care, including assessment, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to specialists and dental providers. School-based health centers must also provide assessments for mental health and substance abuse disorders, crisis intervention, counseling, treatment, and referrals for more specialized mental health and substance abuse treatment services. The new federal funding is targeted to communities that have historically demonstrated difficulty in accessing health, mental health, and substance abuse disorder services, and to communities with a large population of uninsured, underinsured, or individuals enrolled in public insurance programs. Constance N. Parker discusses how these provisions can support North Carolina school-based and school-linked health centers in her sidebar.

Additionally, PPACA includes several provisions aimed at hospitals. Hospitals are leading safety net providers in North Carolina and across the country. Under the federal

q. Activities of daily living include eating, dressing, bathing, toileting, transferring, and continence.

r. Premiums will not increase with age as long as the person stays continuously enrolled; however, the DHHS Secretary can call for an across-the-board premium increase if needed to ensure the financial solvency of the plan.

s. PPACA provides states with additional Medicaid home- and community-based options. For example, PPACA allows states to provide home- and community-based services to people with incomes up to 300% FPL (\$32,490/year for an individual, \$43,710/year for a couple in 2009) without a federal Medicaid waiver. The Act expands the Money Follows the Person Rebalancing Demonstration, which provides enhanced federal funding to help people transition from an institutional setting back to the community after spending at least 90 days in an institution. PPACA creates the State Balancing Incentive Program, which provides states with enhanced federal match rates to increase the proportion of long-term care dollars spent on home- and community-based services (rather than institutional care).

Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals that participate in Medicare must screen anyone who seeks services at a hospital emergency department, regardless of ability to pay.⁴⁴ If the person has a medical emergency, then the hospital must either stabilize the condition or transfer the person to another hospital, as appropriate. PPACA includes several provisions aimed at expanding funding for trauma centers, emergency care coordination, and emergency services for children.⁴⁵

Many hospitals also have charity care policies to provide free or reduced cost services to low-income uninsured people. In FY 2008, North Carolina hospitals provided \$694 million in free care. Sixty-four percent (72 of 112) of community hospitals in North Carolina have some information about financial assistance policies online, and 39 (35%) have comprehensive policies online.⁴⁶

More North Carolina hospitals will be required to have and publicize their charity care policies as a result of PPACA. Beginning with the taxable year after the date of enactment, tax-exempt hospitals will have to meet new requirements to maintain their tax-exempt status.⁴⁷ In addition to providing emergency services, these hospitals must conduct a community needs assessment at least once every three years and adopt an implementation strategy to address those needs. They must also have a financial assistance policy that describes the eligibility criteria for this assistance and is publicized to the community. Finally, they must limit charges to people eligible for assistance to amounts generally billed. Hospitals that do not meet these requirements can be assessed a tax equal to \$50,000 and can have their tax-exempt status revoked.

The Act also expands the 340B discount drug program.⁴⁸ The 340B program provides deeply discounted outpatient drugs to certain safety net providers, including FQHCs, health departments, and some hospitals. PPACA expands the types of hospitals that are eligible for this deeply discounted prescription drug program to include children's hospitals, free-standing cancer hospitals, critical access hospitals, and sole community hospitals. This expansion will be particularly helpful to the 23 critical access hospitals in North Carolina, which can now qualify for deeply discounted outpatient drugs.

PPACA includes statutory language that gives the DHHS Secretary the authority to award grants to eligible entities to support community-based collaborative care networks to provide comprehensive, coordinated, and integrated health care services for low-income populations.⁴⁹ North Carolina should be well-positioned to capture some of these grant funds if funding is later appropriated for this purpose. This new program closely mirrors the North Carolina initiative

to create community collaborations of care for low-income uninsured people. North Carolina currently has 36 public and private funded networks of care servicing low-income uninsured North Carolinians in 68 counties across the state.^{t,50,51}

Health Professional Education

Congress recognized that more people are likely to seek services as they gain health insurance coverage. This may exacerbate any existing health professional shortages and create new demands on other providers.

PPACA includes many provisions to address workforce shortages. *However, unlike many other sections of the Act, PPACA primarily authorizes rather than appropriates new funding to expand and strengthen the health care workforce.* PPACA authorizes funding to create a National Health Care Workforce Commission to identify workforce needs over the next 10 and 25 years and to identify strategies to address these needs.⁵² The Commission is charged with looking at all types of health care workers, including health care professionals (e.g., physicians, nurses, physician assistants, and mental health and substance abuse professionals), as well as paraprofessionals (e.g., direct care workforce and patient navigators). The Act authorizes funding to expand training of the primary care workforce,⁵³ geriatrics,⁵⁴ pediatrics,⁵⁵ mental health and substance abuse providers,⁵⁶ public health professionals,⁵⁷ allied health,⁵⁸ dentistry,⁵⁹ nursing,⁶⁰ underrepresented minorities and/or low-income populations,⁶¹ direct care workers,⁶² and patient navigators.⁶³ The Act also authorizes new initiatives to increase the cultural competency of the existing workforce, teach health care professionals to meet the needs of people with disabilities, and enhance training for quality improvement and patient safety.⁶⁴

PPACA also includes provisions to address the maldistribution of health care providers. For example, PPACA increases Medicare reimbursement rates (FY 2011-2015) for primary care providers and general surgeons practicing in underserved areas.⁶⁵ The Act also ties Medicaid reimbursement for primary care procedures to Medicare rates (thus also effectively increasing Medicaid rates for primary care providers in rural and underserved areas).⁶⁶ Further, PPACA *appropriates* \$1.5 billion over five years (FY 2011-2015) to expand the National Health Service Corps (NHSC) to provide loans or scholarships to health care professionals who agree to practice in underserved areas.⁶⁷ In this issue of the *Journal*, John Price discusses the new NHSC provisions. The bill also authorizes new funding to help train, recruit, and retain health care professionals

t. Most (31 of the 36) community collaborations receive some state funding from HealthNet (administered through the Office of Rural Health and Community Care), and many also receive foundation or community funds to help support their operations. Technical assistance to these community collaboratives is provided by the Care Share Health Alliance or the Office of Rural Health and Community Care.

in underserved areas.⁶⁸ Thomas C. Ricketts and Elizabeth Walker discuss the workforce provisions in the health reform legislation more thoroughly in their commentary.

Quality

PPACA also includes funding and new requirements to improve health care quality. It builds on the funding to promote diffusion and implementation of HIT that was part of the American Recovery and Reinvestment Act. The HIT provisions are explored more extensively in Steve Cline's commentary in this issue of the *Journal*. PPACA invests heavily in prevention and comparative effectiveness research. The Act also directs the DHHS Secretary to establish quality measures, requires providers to report data on these measures, provides more meaningful quality information to the public, and begins to pay providers and insurers for improved quality.

Prevention

PPACA includes \$500 million in FY 2010, increasing to \$2 billion in FY 2015, to create a Prevention and Public Health Fund that will be used to expand prevention, wellness, and public health activities.⁶⁹ The nationwide prevention activities will be led by a new National Prevention, Health Promotion, and Public Health Council, which will include the secretaries or heads of the federal agencies with jurisdiction over issues that affect health.^{u,70} The Council is charged with "developing a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States."⁷¹

The Prevention and Public Health Fund can be used for many purposes specified in the Act, including broad-based education campaigns. For example, the Fund can be used to plan and implement a national outreach and education campaign to promote health improvement,⁷² and to develop a five-year national oral health prevention and education campaign.⁷³ The Fund can also be used to award competitive grants (i.e., community transformation grants) to state and local governmental agencies and community-based organizations to implement evidence-based, multifaceted community preventive health activities.⁷⁴ Entities that compete for this grant must propose a comprehensive multifaceted intervention that includes policy, environmental, programmatic, and infrastructure changes to promote healthy living, reduce disparities, and prevent chronic diseases. The state and local communities can seek community transformation grants to create healthier school

environments (including healthy food options and physical activity); promote healthy lifestyles and emotional wellness; assess and implement worksite wellness programs and incentives; and reduce racial and ethnic disparities and the social, economic, and geographic determinants of health. The Fund also can be used to increase immunization rates among children, adolescents, and adults.⁷⁵

The Act also authorizes, but does not provide direct appropriations for, worksite wellness,⁷⁶ dental caries management,⁷³ epidemiology laboratory capacity,⁷⁷ healthy aging for the pre-Medicare population,⁷⁸ community-based diabetes prevention initiatives,⁷⁹ congenital heart disease surveillance system,⁸⁰ and a young women's breast health awareness and support program.⁸¹ It is possible that some of these programs may be funded through the Prevention and Public Health Fund.

In addition to the funding appropriated to the Prevention and Public Health Fund, Congress appropriated additional funding for specific prevention activities. For example, PPACA appropriates \$75 million in each FY 2010-2014 for grants to states and some competitive demonstration grants for personal responsibility education that includes comprehensive sexuality education (including abstinence), contraception education, and adulthood preparation.⁸² Congress appropriated \$100 million (FY 2010) increasing to \$400 million (FY 2014) for maternal, infant, and early childhood home visiting programs,⁸³ and \$25 million in each FY 2010-2019 for pregnancy assistance funds to assist pregnant and parenting teens and women who are in high school or college.⁸⁴ Additionally, PPACA mandates that chain restaurants and vending machines provide nutritional content that is prominently displayed,⁸⁵ and that employers provide new breastfeeding mothers time and a private location to express milk for up to one year after a child is born.⁸⁶ In his commentary, State Health Director Jeffrey Engel explains how the prevention provisions in PPACA can help improve population health in the state and how the new funding opportunities can be used to support the implementation of many of the recommendations included in the state's *Prevention Action Plan*.⁸⁷

In addition to the population health prevention efforts, the Act includes more comprehensive coverage of clinical preventive services. For example, the Act requires private insurers and Medicare to cover clinical preventive services without any cost sharing. This includes all of the services that are recommended by the US Preventive Service Task Force (USPSTF) with an "A" or "B" rating and immunizations that are recommended by the Advisory Committee on

u. The new Council will include the secretaries of the US Department of Health and Human Services, Agriculture, Education, Transportation, Labor, and Homeland Security, as well as the Chair of the Federal Trade Commission, Administrator of the Environmental Protection Agency, Director of the Office of National Drug Control Policy, Director of the Domestic Policy Council, Assistant Secretary for Indian Affairs, Chair of the Corporation for National and Community Service, and the head of any other agency the Chairperson determines is appropriate.

Immunization Practices. In addition, private insurers must provide coverage for preventive care and screenings for women and for infants, children, and adolescents that are recommended by the Health Resources and Services Administration (i.e., the Bright Futures Initiative) and additional preventive care and screenings recommended by the USPSTF for Medicare beneficiaries.⁸⁸ State Medicaid programs are already required to provide preventive services to children under age 21 without cost sharing as part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. However, state Medicaid programs are not required to provide preventive services to adults, although many cover a number of the recommended preventive screenings and services.⁸⁹ Further, state Medicaid agencies can impose modest copayments or other cost sharing for preventive services provided to adults. In order to encourage state Medicaid agencies to provide comprehensive coverage of preventive services for adults, PPACA enhances the federal match rate for states that choose to cover all the recommended preventive services with no cost sharing.⁹⁰

Comparative Effectiveness Research

PPACA creates a new Patient-Centered Outcomes Research Institute.⁹¹ This Institute is charged with establishing research priorities and funding comparative clinical effectiveness research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of two or more treatments, services, drugs, and biologicals, or medical devices. The Act is very specific that the Institute does not have the authority to use the research to mandate coverage, reimbursement, or other policies for public or private payers. The DHHS Secretary, however, can use evidence or findings from the comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs for Medicare from among alternative treatment options, as long as the Secretary does not use the research in a manner that treats the life of an older adult, a person with disabilities, or someone with a terminal illness as having lower value than that of a person who is younger, nondisabled, or not terminally ill. PPACA appropriates \$10 million in FY 2010, increasing to \$150 million in FY 2012, and assesses insurers, self-funded plans, and Medicare thereafter to support this research. The findings from the comparative effectiveness research are to be widely distributed to physicians, health care providers, patients, and other groups. In this issue of the *Journal*, Tim Carey discusses the importance of comparative effectiveness research and the involvement of North Carolina research groups in conducting this research. In addition, North Carolina State Senator Josh Stein discusses the North Carolina Comparative Effectiveness Study Committee in his sidebar.

Quality and Outcome Data

Under PPACA, the DHHS Secretary must develop a strategy to improve the delivery of health services, patient health outcomes, and population health. As part of this effort, the Secretary must develop strategies to increase the use of health care data to improve quality, outcomes, efficiency, and transparency; change federal payment policies to incentivize quality and efficiency; disseminate best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care acquired infections; and reduce health disparities.⁹² The Secretary is required to submit a report annually to Congress on the progress in achieving these goals and any changes to the short- and long-term goals. In addition, PPACA directs the President to convene an Interagency Working Group on Health Care Quality to assist with the goals of improving health care quality.⁹³

The DHHS Secretary is also directed to develop quality measures to assess the performance and health outcomes of health plans or providers of services.⁹⁴ PPACA directs the Secretary to seek public input into the measures before finalizing the use of any quality measure.⁹⁵ Ultimately, the goal is to make these data available to the public through standardized websites.⁹⁶ For example, not later than January 1, 2011, the Secretary must develop a Physician Compare website with information on physicians enrolled in the Medicare program and other professionals who participate in the Physician Quality Reporting Initiative.⁹⁷ Similarly, the Secretary will develop reporting requirements for group health plans and health insurance issuers by March 23, 2012.⁹⁸ The Secretary is also directed to develop quality measures and reporting requirements for long-term care hospitals, inpatient rehab hospitals, prospective payment system-exempt cancer hospitals, and hospice;⁹⁹ skilled nursing facilities and home health agencies;¹⁰⁰ and ambulatory surgical centers.¹⁰¹

PPACA clearly puts greater emphasis on collecting and reporting quality data than we have in our current health care system. However, the Act goes further by directing the DHHS Secretary to begin paying health care professionals, hospitals, and health plans based on the health outcomes they achieve, rather than payments based purely on the procedures or services provided. This is one of the ways in which the Act begins to change the way we organize and pay for health care. For example, Medicare will begin paying physicians based on a composite of quality-based measures beginning in 2013.¹⁰² Similarly, physicians are provided financial incentives if they have successfully completed their Maintenance of Certification program assessment.¹⁰³ Beginning in FY 2013, hospitals will have an across-the-board cut to diagnosis-related group (DRG) payments. However,

v. The quality measures will be based on care provided to people with acute myocardial infarction, heart failure, pneumonia, surgical infections (measured by the Surgical Care Improvement Project), and health care associated infections.

hospitals that are meeting certain quality standards will receive enhanced payments.^{v,104} Certain hospitals will see their payments reduced for health care acquired conditions and excess hospital readmissions.¹⁰⁵ Similarly, Medicare Advantage plans will experience cuts in their reimbursement beginning in 2012.¹⁰⁶ However, Medicare Advantage plans that are providing high quality care will be rewarded through higher reimbursement.

In his commentary, Stephen Wallenhaupt discusses the new provisions in PPACA that address quality and reflects on how well-positioned the state is to meet these new requirements based on our pre-existing efforts to improve quality and patient safety.

Cost Containment

The Act strives to “bend the health care cost curve” by testing new models of organizing and paying for health care. PPACA creates a new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models to reduce program expenditures.¹⁰⁷ Congress appropriated \$5 million for the design and implementation of these models in FY 2010 and \$10 billion to implement and evaluate the models in FY 2011-2019. The Act includes many new models of care delivery to be tested in the Medicare and Medicaid programs as part of this effort to change the structure and financing of our health care delivery system. For example, PPACA directs the DHHS Secretary to establish a shared savings program with “accountable care organizations” (ACOs), organizations of providers who agree to assume responsibility for the quality, cost, and overall care of their Medicare fee-for-service beneficiaries. The ACO will be eligible for shared savings if it meets certain quality standards and if the estimated expenditure for the beneficiary is below an applicable benchmark expenditure.¹⁰⁸ The Act also directs the DHHS Secretary to establish a national pilot program on payment bundling (which includes inpatient, physician services, outpatient hospital services, and post-acute care services).¹⁰⁹ In addition, PPACA directs the Secretary to develop an independence at home demonstration project, which will have primary care teams visit high-risk, chronically ill Medicare beneficiaries at home to prevent future hospitalizations.^{110,111} In addition, the Act creates a hospital readmissions reduction program¹¹² and a community-based care transition program to provide transition services across a continuum of care to high-risk Medicare beneficiaries who have multiple chronic illnesses or other risk factors associated with hospital readmissions.¹¹³

PPACA also makes changes in the Medicaid program to support or test new models of care. Perhaps the most important provision for North Carolina is the state option

to provide a medical or health home for Medicaid enrollees with chronic conditions. This model is similar, in most respects, to our existing Community Care of North Carolina model.¹¹⁴ A provider, or a health team, can be designated as the individual’s “health home” and receive additional per-member per-month payments for use on comprehensive care management, care coordination, and health promotion; comprehensive transitional care; patient and family support; referral to community and social services; and use of HIT. States that elect this option are eligible for an enhanced federal match rate of 90% for the first eight fiscal year quarters in which the plan amendment is in effect.¹¹⁵ The DHHS Secretary is also directed to establish a demonstration project to test bundled payments in Medicaid;¹¹⁶ a Medicaid global payment demonstration project to test the impact of changing payments from fee-for-service to global capitation;¹¹⁷ a pediatric accountable care demonstration project;¹¹⁸ a five-year period for demonstration projects to test models to better coordinate care for dual-eligible beneficiaries;¹¹⁹ and a Medicaid emergency psychiatric demonstration project to pay for emergency services provided to individuals in private institutions for mental illnesses.¹²⁰

These demonstrations are intended to test and evaluate new models to improve care coordination, transitions of care from one care setting to another, quality, health outcomes, and cost effectiveness of the care provided. However, as small scale demonstrations they have limited ability to control overall health care spending. Thus, Congress gave the DHHS Secretary the authority to expand these models if the Secretary determines that the model improves quality of patient care and reduces spending.¹⁰⁷

The bill also cuts certain payments to Medicare Advantage plans and certain health care providers. For example, the Congressional Budget Office (CBO) estimates that the plan will reduce Medicare payments by \$156.6 billion over 10 years by reducing annual market basket updates for inpatient acute hospitals, home health agencies, skilled nursing facilities, hospice, and other Medicare providers.^{w,121} Additionally, PPACA is estimated to save \$135.6 billion over 10 years by cutting excess payments to Medicare Advantage plans.¹ Independent studies have shown that Medicare Advantage plans are paid, on average, 14% more than traditional Medicare for comparable beneficiaries.¹²² PPACA phases out these excess payments to plans over time while concurrently providing bonus payments to Medicare Advantage plans that achieve certain quality ratings.

The Act also anticipates significant cost savings by reducing Medicare and Medicaid payments to hospitals. Historically, hospitals that serve a higher proportion of Medicaid, low-income, and uninsured patients than other hospitals received

v. The quality measures will be based on care provided to people with acute myocardial infarction, heart failure, pneumonia, surgical infections (measured by the Surgical Care Improvement Project), and health care associated infections.

w. Market baskets are estimates developed to update provider reimbursement in order to adjust for inflation.

higher reimbursement from Medicare and Medicaid. These hospitals received extra “disproportionate share hospital” (DSH) payments because Congress recognized that they had less ability to shift the uncompensated costs of caring for the uninsured or Medicaid patients onto other commercially insured patients. The DSH payments to hospitals will be phased down over time as the numbers of uninsured people decline in each state. CBO estimates that the reduction in DSH payments will save \$14 billion over 10 years in the Medicaid program¹²³ and \$22.1 billion over 10 years in the Medicare program.¹²⁴ Further, PPACA increases drug rebates in the Medicaid program, which is estimated to reduce federal costs by \$38.1 billion over 10 years.¹²⁵

PPACA includes provisions to streamline health insurance administration and implement HIT.¹²⁶ The DHHS Secretary is directed to develop standards for eligibility verification, claims and encounter information, enrollment and disenrollment in health plans, prior authorization, claims payment, and reduction in the number and complexity of forms for patients and providers. The CBO estimates that administrative simplification will reduce overall costs to the federal government by \$11.6 billion over 10 years (\$7.3 billion for the Medicaid program and \$4.3 billion for spending in the HIE).¹ The Act also includes new provisions and funding to support more aggressive efforts to eliminate fraud and abuse and to recover overpayments.¹²⁷

Financing

As noted earlier, CBO estimates that the costs of the new coverage provisions and the other health-related spending would amount to \$938 billion over 10 years.¹ However, this cost is more than offset by new revenues and other cuts to the Medicaid and Medicare program. For example, CBO estimates that individuals who are not exempt from the coverage mandate would pay \$17 billion in penalties from 2015 to 2019, and employers would pay \$52 billion. PPACA also includes an excise tax on high-premium insurance plans (the so-called “Cadillac plans”). This tax limits the tax deductibility of any employer-sponsored plan that exceeds \$10,000 for individual coverage or \$27,500 for family coverage (effective 2018).^{x,128} The excise tax on high-cost plans is expected to yield \$32 billion between 2018-2019, and more in the following decade.

In addition to the coverage provisions, there are other provisions which would increase taxes on higher income individuals. Beginning in 2011, Medicare beneficiaries earning more than \$85,000/year and couples earning more than \$170,000/year will have to pay higher premiums for their Medicare Part D prescription drug benefits.¹²⁹ Individuals of any age will pay an additional 0.9% increase in their payroll taxes for any annual earnings in excess of \$200,000 for an individual or \$250,000 for a couple and

will have to pay a 3.8% Medicare tax on their unearned income.¹³⁰ Over the next 10 years, PPACA is expected to raise \$60.1 billion in fees on insurers;¹³¹ \$27 billion in fees on pharmaceutical companies;¹³² \$20 billion in fees on manufacturers of medical devices;¹³³ and \$2.7 billion in taxes on tanning salons.^{134,135}

In total, the provisions that affect direct spending (i.e., Medicaid and Medicare) are expected to reduce the costs of those programs by \$511 billion, and the other provisions affecting revenues would reduce the deficit by \$420 billion, thus leading to an overall reduction of the federal deficit by \$143 billion over 10 years (or \$124 billion, not counting the education provisions in the reconciliation bill).

Conclusion

PPACA addresses all three key components of health reform. The legislation does the most to improve access to care by expanding Medicaid to those with lower incomes and making health insurance coverage more affordable to those with incomes up to 400% FPL who are not covered through their employer. In this issue of the *Journal*, Adam Searing and Adam Linker discuss the impact of PPACA on consumers and the uninsured. PPACA also invests in expanding the health care safety net and includes provisions that, if funded, will expand and strengthen provider supply. The Act will help improve the quality of care we receive, which should lead to better health outcomes through the legislation’s investments in prevention, integrative care, comparative effectiveness research, and enhanced quality measurement and reporting. PPACA should lead to reduced fraud and abuse and begin to reduce unnecessary costs in the system including excess administrative costs. However, while the legislation is expected to reduce the federal deficit by \$124 billion over the next 10 years, the legislation does less

Useful Resources

- Patient Protection and Affordable Care Act (HR 3590, signed into law March 23, 2010). http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf.
- Health Care and Education Reconciliation Act of 2010 (HR 4872, signed into law March 30, 2010). http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf.
- Kaiser Family Foundation. Focus on Health Reform: Summary of New Health Reform Law. Publication no. 8061. <http://www.kff.org/healthreform/upload/8061.pdf>.
- Congressional Budget Office. Manager’s Amendment to Reconciliation Proposal. <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

x. The reconciliation bill included higher thresholds for people in high-risk professions or for retirees.

in the area of cost containment than in the areas of access and quality. PPACA creates the necessary infrastructure that can lead to longer-term health care cost savings by testing new health care delivery models and payment systems. But, until these systems are tested, evaluated, and, if successful, implemented more broadly, we are unlikely to experience significant reductions in the health care cost curve.

Not surprisingly, PPACA is not a perfect bill and does not address all of our current health system woes. All of us, whether providers, consumers, insurers, business, or community leaders, are touched by the health care system and feel deeply

about how health care is financed and delivered. PPACA was a product of significant political compromises, as we would expect with any comprehensive legislation that affects 17.3% of the country's gross domestic product.¹³⁶ Our understanding of the legislation will change over time, as many of the details are yet to be worked out through federal regulations. Further, we should expect revisions as we learn, over time, what works well and what needs to be changed. Despite these immediate shortcomings, the legislation begins to address some of the fundamental flaws in our current health care system. **NCMJ**

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19. Sec. 10108 of PPACA.
20. Secs. 1421, 10105 of PPACA.
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32. Sec. 1003 of PPACA.
33. Secs. 1001, 10101 of PPACA.
34. Secs. 4103-4105, 10402, 10406 of PPACA.
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