The Patient Protection and Affordable Care Act: no rhetoric, just the facts

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The Patient Protection and Affordable Care Act is the most comprehensive reform of the United States' health-care system since Medicare and Medicaid were created in the 1960s. The law will expand access to health insurance for millions of uninsured Americans, make that coverage more secure, and promote new delivery systems and payment paradigms that focus on prevention and high-quality care.

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[1] The law is designed to expand access to health insurance to the uninsured, provide enhanced consumer protections for those with private health insurance, stabilize and close gaps in the Medicare program, prioritize preventive care, establish the personal responsibility to have health insurance' and explore delivery system reforms that will reward quality of care and patient outcomes. The implementation of the law began in September 2010 and will continue until January 2014, when all provisions will be in place. The description that follows is based on the law as written and, as such, assumes that the Supreme Court upholds the entire law.

Expanding access to health insurance[2]

It is estimated that about 32 million uninsured Americans will gain health-insurance coverage under the PPACA. There are six mechanisms that comprise that expansion: Medicaid expansion, enhanced consumer protections in the private health-insurance market, a requirement for large employers to offer insurance or pay a fine, tax credits to increase the affordability of insurance for small businesses, the creation of state-based competitive marketplaces where the uninsured can shop for insurance, and the individual mandate to enroll in a health-insurance plan.

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Medicaid expansion

Beginning in 2014, the PPACA will expand access to Medicaid for individuals and families with modified adjusted gross income under 133% of the federal poverty level. In 2012, a family of 4 with an annual income of $30,657 would qualify for Medicaid. Unlike most current state Medicaid programs, the expansion will include childless adults. Each state splits the cost of Medicaid between state and federal funds. Under the PPACA, the cost of those newly eligible for Medicaid will be covered 100% by federal dollars for the first 3 years, after which the states will be required to contribute a percentage so that by 2020 federal funds will cover 90% of the costs of the newly eligible and the states will cover the remaining 10%. It is estimated that about 12-13 million uninsured Americans will benefit from this expansion.

Consumer protections

For those who already have or intend to purchase private health insurance, the PPACA implements consumer protections to make that coverage more secure and affordable. One of the most popular provisions is "guaranteed insurability," which requires that preexisting conditions be covered without waiting periods. Since September 23, 2010, children under 18 years of age cannot be denied coverage of a preexisting condition and the same provision will cover adults beginning January 1, 2014. Insurance companies will also have to use "community rating" in setting the price of insurance. This practice, which will begin in 2014, requires that all consumers, with a few exceptions, within a defined coverage area must be charged

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the same amount for insurance, regardless of their health status or gender. In a March 2012 report, the National Women's Law Center estimated that gender rating costs women $1 billion annually in higher premiums than men pay for equivalent coverage.[3] Higher premiums are allowed for older age, smoking, and geographic area.

An insurance practice known as rescission (the unmaking of a contract), whereby consumers in the individual market risked loss of coverage if they developed an illness, is now illegal. Lifetime limits on benefits covered ended in September 2010, and annual limits on benefits covered will end January 1, 2014. This lifting of benefit caps reduces out-of-pocket spending for individuals with serious chronic illnesses, such as cancer, who frequently could exhaust their benefits while they are still under treatment. In addition, young adults may now stay on their parents' health-insurance plan until their 26th birthday. The young adult does not have to be a student and can be working and/or married. As of December 31, 2011, 2.5 million young adults have gained insurance coverage through this provision.

Another important requirement of the PPACA, called the Medical Loss Ratio (MLR), is intended to help control the cost of insurance. Under the PPACA private health-insurance companies are now required to spend at least 80% of the premium dollar (individual and small group plans) or 85% of the premium dollar (large group plans) on health-care expenses and quality improvement activities, rather than administrative and marketing costs and profit. In August 2012, consumers will receive rebates if their insurance company did not achieve the MLR in 2011. The Kaiser Family Foundation estimates that consumers will be eligible for rebates worth up to $1.3 billion. About a third of these rebates are expected to go to consumers in the individual market. Rebates will also go to employers, and in some cases will be passed on to employees.[4]

Finally, most private health-insurance plans that propose premium rate increases of 10% or more from one year to the next are now subject to oversight by state Rate Review programs and the US Department of Health and Human Services.[5] Insurance companies are required to provide public justification for the rate increase (posted on www.HealthCare.gov) and take public comment. As of March 10, 2012, the justifications and analysis of 186 rate increases covering 1.3 million people have been posted. As of the last quarter of 2011, states reported that premium increases dropped by 4.5%, requests for premium increases have been rejected or lowered in at least nine states, and insurance premiums have decreased in Nevada.[6]

Employer-sponsored insurance[7,8]

Beginning in 2014, buinesses with more than 50 employees must provide health insurance or pay a penalty. In most cases, the penalty will be less than the cost of providing health insurance, which has triggered much speculation as to whether or not large businesses will stop offering this benefit. Small businesses with 50 or fewer employees pay no penalty if they do not offer health insurance to their employees. Currently, those businesses with 25 or fewer employees may be eligible for a tax credit of up to 35% of the employer's contribution to the employee's health-insurance premium. This tax credit will increase to 50% for certain employers in 2014. It is estimated that about 4 million small businesses are eligible for this tax credit.

State-based health-insurance exchanges[2]

Beginning in 2014, individuals who do not have employer-sponsored coverage will be able to shop for insurance in their state-based "health-insurance exchange." A similar exchange for businesses with fewer than 100 employees will also be established. The exchange will function as an online competitive marketplace for the purchase of qualified private health insurance. Individuals and business owners can view apples-to-apples comparison of plans written in straightforward language. Individuals and businesses will be able to determine if they are eligible for tax credits to help purchase insurance or if, in the case of individuals, they qualify for Medicaid or the Children's Health Insurance Program, also known as CHIP. If states choose not to establish their own exchange, the federal government will establish an exchange within that state. Of note is that beginning in 2014, members of Congress will obtain their health insurance through their state health-insurance exchange.

Individual mandate

Beginning January 1, 2014, the law establishes the personal responsibility to enroll in a health-insurance plan or pay a penalty. Known as the individual mandate, this is one of the most controversial provisions of the law. The Supreme Court is expected to rule on the constitutionality of this provision by the end of June 2012. Exemptions to the mandate include: religious objection, being without coverage for less than 3 months (because of job transitions, for example), incarceration, and if the lowest cost of a qualified plan available to an individual is more than 8% of that person's income. In 2014, the penalty for not enrolling in a health-insurance plan will be the greater of $95 or 1% of taxable income. By 2016, the penalty will rise to the greater of $695 or 2.5% of taxable income.

The PPACA simultaneously provides financial assistance in the form of tax credits to make insurance more affordable to low-income individuals and families. Sliding scale tax credits will be available to individuals and families whose income is between 133% and 400% of the federal poverty level. Currently, for a family of 4, this is an annual income range between $20,657 and $92,200. The inclusion of the individual mandate in the law encourages everyone to take the personal responsibility to enroll in an insurance plan. With most Americans enrolled, insurance risk pools will be much larger and include healthier individuals. Larger insurance risk pools enable coverage of preexisting conditions and community rating of health-insurance premiums without driving the cost of insurance even higher. If the Supreme Court determines that the individual mandate is unconstitutional, it is likely that coverage of preexisting conditions and community rating will also be eliminated.

Caring for specific populations

Prevention

A major focus of the PPACA is to encourage preventive care. Medicare, and all new insurance plans (since September 2010) must cover without copay, co-insurance, or deductible, all US Preventive Services Task Force services rated A (high certainty that the net benefit is substantial) or B (high certainty the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial).

In addition, the PPACA asked the Institute of Medicine to develop recommendations for additional preventive services specifically for women. That report, published in July 2011, includes recommendations for improved screening for cervical cancer, counseling for sexually transmitted infections and HIV, screening for gestational diabetes, lactation counseling, screening for domestic violence, a fuller range of contraceptive education, counseling, methods, and services, and 1 well-woman preventive care visit annually.[9] These services will begin in August 2012, with some exemptions for religious and religiously affiliated institutions.

Medicare

In addition to the preventive services described above, Medicare recipients are now eligible for 1 no-copay annual wellness visit. Of note is that the PPACA is closing the gap in the Medicare Part D prescription drug benefit, known as the "donut hole." Previously, when Medicare beneficiaries reached a total of $2,930 in total drug spending, they became responsible for 100% of their drug costs until total spending had reached $6,657. In 2012, when beneficiaries reach the coverage gap, they will automatically receive a 50% discount on the cost of brand name medications and a 14% discount on generic medications. By 2020, the coverage gap will be eliminated and Medicare beneficiaries will pay a stable copay throughout the year, regardless of total drug spending. In 2011, nearly 4 million seniors received $2.1 billion in discounts on prescription medications while in coverage gap.[10] The sum total of stronger benefits to seniors and slowing cost growth is currently estimated to save the average beneficiary about $4,200 during 2011-2021. For beneficiaries with high prescription drug use, the savings may be as high as $16,000.[10]

Health-care delivery system reforms

Physician workforce

Under the PPACA, a number of steps are being taken to strengthen the primary-care workforce. Unused residency training slots have been redistributed to primary-care and general-surgery training programs in states with the greatest need. The Teaching Health Center Graduate Medical Education Payment Program has been established to enable the development of new community-based ambulatory primary-care residency training programs. The National Health Services Corps has received an additional $1.5 billion over 5 years to increase loan repayments for physicians who join the Corps. The Corps has tripled in size since 2008 and physicians may now work part-time in an underserved area or clinic and receive a prorated loan repayment. Medicare is providing a 10% bonus payment to primary-care physicians and general surgeons who practice in shortage areas (funded from 2011-2015). Beginning in 2013, a 2-year pilot will increase Medicaid payments to Medicare rates for primary-care physicians in an effort to improve access for Medicaid recipients.

Focus on quality, rather than quantity of care

The PPACA begins the move toward payment reform that incentivizes high-quality outcomes from care rather than our current fee-for-service system that incentivizes high-quantity care. The law established the Center for Medicare and Medicaid Innovation (CMMI) whose mission includes testing innovative payment and health-service delivery models with the goal of reducing the cost of care and enhancing quality. Accountable Care Organizations (ACOs) are the most visible first effort led by the CMMI. ACOs are designed to facilitate care coordination and cooperation among providers to improve the quality of care and reduce cost for Medicare beneficiaries. Physicians and providers in an ACO assume responsibility for spending, quality, and health outcomes and share in savings achieved as long as certain outcome and quality

metrics are met. There are several different models of ACOs and different levels of risk assumed by providers. Complete details can be found at the Center for Medicare and Medicaid Services.[11] Bundled payments for common surgical procedures and medical conditions is another approach that is being tested.

The Patient-Centered Outcomes Research Institute

PCORI is a nonprofit, nongovernmental corporation created to conduct comparative effectiveness research in order to provide physicians and patients with the best available evidence with which to make decisions about health care. Since March 2011, the PCORI Methodology Committee has been working to define "patient-centered outcomes research" with significant public and provider involvement and has developed a draft research agenda.[12]

Paying for the PPACA

The Congressional Budget Office has consistently found that the PPACA is fully funded and will reduce the federal deficit over the next decade. It is important to note that the law assumes that the sustainable growth rate cuts to physician Medicare reimbursement will occur. Given that Congress has repeatedly avoided these cuts, the law may in reality be underfunded. Funding comes from a combination of revenue and savings. The law creates a new tax increase of 2%-2.5% on the pharmaceutical, medical device and health-insurance industries. The pharmaceutical industry is also funding rebates to the Medicare Part D prescription drug plan covering the discounts when beneficiaries are in the donut hole. Over time, hospitals will receive reduced disproportionate share payments to care for the uninsured and reduced or no payment for preventable hospital re-admissions and infections. Taxpayer subsidies to Medicare Advantage plans will gradually be reduced so that these plans receive the same funding as traditional Medicare, saving $132 billion over the next decade. Caps on profits of private health-insurance companies will reduce the cost of health insurance.

Individuals who earn more than $200,000 annually and couples who earn more than $250,000 annually will pay a 0.9% increase in the Medicare payroll tax on income above those thresholds. Medicare premiums are now indexed to income with individuals and couples earning more than $85,000 and $170,000, respectively, paying more.

Medicare is aggressively prosecuting fraud and abuse. In fiscal year 2011, the administration recovered nearly $4.1 billion in fraudulent payments, the largest sum ever recovered in one year.[13]

Conclusion

In sum, the PPACA is a comprehensive law that touches most aspects of medical practice. If the law is fully implemented most, though not all, Americans will have more secure health insurance with better benefits. New delivery models, such as ACOS, will create significant opportunities for physician leadership as well as the need for coordinated teamwork. Although there remains uncertainty as to whether or not some provisions of the law will be found unconstitutional, so much implementation of the law has already occurred or been set in motion that it is likely that certain aspects of the law, in particular the health-care delivery and payment reforms, will remain in place regardless of the outcome of the Supreme Court challenge to the law.

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