Running head: AFFORDABLE CARE ACT

Affordable Care Act

Susan Hodges

Polk State College

Affordable Care Act

In November 2009, the House of Representatives created the Affordable Health Care for America Act (or HR 3962) also known as Obamacare. The original draft of this bill never became law. Eventually a new and revised bill with the same number passed Congress and was signed by the President on June 25, 2010. This Bill has not been without controversy from the beginning. It is a mystery to most people, and very little has been done to educate the American public to its benefits and purpose.

Healthcare is a huge economic driver so this Bill has the potential to change gross domestic product (GDP) spending and the use of limited healthcare resources**.** On a per person basis and as a percentage of GDP the U.S. dramatically outspends other nations. (Charting the economy.com, 2009, table 1). Despite spending more on healthcare than 19 other nations the U.S. life expectancy is considerably shorter. December 2011 the outgoing Administrator of the Centers for Medicare & Medicaid Services, Dr. Donald Berwick, asserted that 20% to 30% of health care spending is waste. Harvard estimated in 1997 100,000 people in the U.S. died due to lack of medical care whether insured or not. ("Wikipedia the free encyclopedia", 2013)

How this will fully affect healthcare spending is yet to be seen as we have only begun the process of enacting this bill. It has been created in phases that enact new provisions of the bill each year until January 1, 2020 when the Medicare Part D donut hole will be completely phased out and all parts of the bill will have been enacted. See below for a brief synopsis of the provisions to be enacted by this bill starting from the date of enactment through 2020 ("Wikipedia the free encyclopedia", 2013):

Upon Enactment:

A.) Food and Drug Administration (FDA) grants drug manufacturers 12 years before generic drugs can be developed and then FDA approves generic versions

.

B.) Medicaid Drug Rebate Increased in most cases.

C.) A non-profit Patient-Centered Outcomes Research Institute is established, independent from government, to undertake comparative effectiveness research.

D.) Creation of task forces on Preventive Services and Community Preventive Services

E.) The Indian Health Care Improvement Act is reauthorized and amended.

F.) Restaurants and food vendors with 20 or more locations are mandated to display the caloric content of their foods on menus, drive-through menus, and vending machines. Additional health information must be available also upon request.

G.) States can apply for an amended plan to extend family planning eligibility through a state option vs. a federal waiver.

June 21, 2010:

A.) Adults with existing conditions became eligible to join a temporary high-risk pool, if uninsured for 6 months and other requirements.

July 1, 2010:

A.) A 10% sales tax on indoor tanning took effect.

B.) President established, a council to be known as the National Prevention, Health Promotion and Public Health Council within the Department of Health and Human Services (HHS).

September 23, 2010:

A.) Insurers prohibited from imposing lifetime dollar limits on essential benefits.

B.) Children permitted to remain on parents' insurance plan until their 26th birthday.

C.) Insurers prohibited from excluding pre-existing medical conditions (except in grandfathered individual health insurance plans) for children under the age of 19.

D.) All new insurance plans must cover preventive care and medical screenings without copayments or deductibles.

E.) Insurers' abilities to enforce annual spending caps was restricted.

F.) Insurers were prohibited from dropping sick policyholders.

G.) Insurers had to reveal details about administrative and executive expenditures.

H.) Insurers had to implement an appeals process for coverage determination and claims on all new plans

I.) Improved methods of fraud detection were implemented.

J.) Medicare was expanded to small, rural hospitals and facilities.

K.) Medicare patients with chronic disease are to be seen every 3 months to evaluate treatment.

L.) Companies, which provide early retiree benefits for individuals aged 55–64, were eligible for a temporary program, which reduces premium costs.

M.) A new website will provide consumer insurance information for individuals and small businesses in all states.

N.) A temporary credit program was established encouraging private investment in new therapies.

O.) All new insurance plans must cover childhood immunizations and adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP) without charging co-payments, co-insurance, or deductibles when provided by an in-network provider.

January 1, 2011:

A.) Only 15% to 20% of gross dollars will be allowed for insurer's administrative costs and profits, subject to various waivers and exemptions. If an insurer fails to meet this requirement, there is no penalty, but a rebate must be issued to the policyholder.

B.) Overseeing the testing of innovative payment and delivery models is done by Center for Medicare and Medicaid Innovation.

C.) Flexible spending accounts cannot be used to purchase over the counter meds except insulin.

September 1, 2011:

Health insurance companies must inform the public when they want to increase health insurance rates for individual or small group policies by of 10% or more

January 1, 2012:

A.) Employers must disclose the value of employee's health insurance coverage on the employee's annual Form W-2's.

B.) Centers for Medicare & Medicaid Services (CMS) will begin the Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions

January 1, 2013:

A.) Income for single individuals in excess of $200,000 annually will be subject to an additional tax of 0.9%. The threshold amount is $250,000 for a married couple filing jointly or $125,000 for a married person filing separately. In addition, a Medicare tax of 3.8% will apply to unearned income, specifically the lesser of net investment income or the amount by which adjusted gross income exceeds $200,000 or $250,000 for a married couple filing jointly; $125,000 for a married person filing separately.

B.) A limit on pre-tax contributions to healthcare flexible spending accounts was capped at $2,500 per year.

C.) Most medical devices are subject to a 2.3% excise tax collected at the time of purchase.

D.) Insurance companies are required to use simpler, more standardized paperwork.

August 1, 2013:

Religious organizations must implement the contraceptive mandate.

January 1, 2014:

A.) Insurers prohibited from discriminating against or charging higher premiums for individuals based on gender or pre-existing medical conditions.

B.) Insurers are prohibited from setting annual spending caps.

C.) The waiting period limitation for group plans must be effective no later than the 91st day after the employee satisfies the substantive eligibility requirements.

D.) Individuals who are not covered by an acceptable insurance policy will be charged an annual penalty of $95 - $695 ($2,085 for families). Exemptions permitted for religious reasons, members of health care sharing ministries, or for those for whom the least expensive policy would exceed 8% of their income.

E.) Medicaid eligibility is expanded; all individuals with income up to 133% of the poverty line qualify for coverage, including adults without dependent children. Some states have declined this.

F.) Two years of tax credits will be offered to qualified small businesses. To receive the full benefit of a 50% premium subsidy, the small business must have an average payroll per full-time equivalent ("FTE") employee of no more than $50,000 and have no more than 25 FTEs. As an example, a 16 FTE firm with a $35,000 average salary would be entitled to a 10% premium subsidy.

G.) A $2,000 per employee penalty on employers with more than 50 employees who do not offer health insurance to their full-time workers, or an employee who is employed on average at least 30 hours of service per week.

H.) For employer-sponsored plans, set a maximum of $2,000 annual deductible for a plan covering a single individual or $4,000 annual deductible for any other plan, some exceptions will be allowed.

I.) Independent Payment Advisory Board created to, reduce Medicare and Medicaid drug reimbursement rate, and cutting other Medicare and Medicaid spending

J.) Revenue increases from a new $2,500 limit on tax-free contributions to flexible spending accounts (FSAs), which allow for payment of health costs.

K.) Implementation of new state-based health insurance exchanges to cover how the exchanges will determine eligibility for uninsured individuals and employees of small businesses seeking to buy insurance on the exchanges, as well as how the exchanges will handle eligibility determinations for low-income individuals applying for newly expanded Medicaid benefits.

L.) Members of Congress and their staff will only be offered health care plans through the exchange or plans otherwise established by the bill instead of the Federal Employees Health Benefits Program that they currently use.

M.) Establish health insurance exchanges, and subsidization of insurance premiums for individuals in households with income up to 400% of the poverty line. The subsidy will be provided as an advanced refundable tax credit.

N.) A new excise tax will go into effect for pharmaceutical companies and is based on the market share of the company; it is expected to create $2.5 billion in annual revenue.

O.) Health insurance companies become subject to a new excise tax based on their market share; the rate gradually rises between 2014 and 2018 and thereafter increases at the rate of inflation. They anticipate the tax will yield up to $14.3 billion annually.

P.) Qualifying medical expenses for deduction on Schedule A tax filings increases from 7.5% to 10% of adjusted gross income.

Q.) Consumer Operated and Oriented Plans (CO-OP), member-governed non-profit insurers, entitled to a 5-year federal loan, can start providing health care coverage.

October 1, 2014:

Federal payments to hospitals that treat large numbers of indigent patients are to be reduced and subsequently allowed to rise based on the percentage of the population that is uninsured in each state.

January 1, 2015:

CMS begins using the Medicare fee schedule to give larger payments to physicians who provide high-quality care compared with cost.

October 1, 2015:

States allowed to shift children eligible for care under the Children's Health Insurance Program to health care plans sold on their exchanges, as long as HHS approves.

January 1, 2016:

A.) States are permitted to form health care choice compacts and allows insurers to sell policies in states participating in the compact.

B.) Threshold for itemizing medical expenses increases from 7.5% of income to 10% for seniors.

January 1, 2017:

A.) A state can apply to the Secretary of Health & Human Services for a "waiver for state innovation" as long as the state passes legislation implementing an alternative

health care plan meeting certain criteria. These states would be exempt from some of the central requirements of the ACA, including the individual mandate, the creation by the state of an insurance exchange, and the penalty employers not providing coverage. They would also receive compensation equal to the aggregate amount of any federal subsidies and tax credits for which its residents and employers would have been eligible under the ACA plan, but which cannot be paid out due to the structure of the state plan. In order to qualify for the waiver, the state plan must provide insurance at least as comprehensive and as affordable as that required by the ACA, must cover at least as many residents as the ACA plan would, and cannot increase the federal deficit. The coverage must continue to meet the consumer protection requirements of the ACA, such as the prohibition on increasing premiums because of pre-existing conditions.

B.) States may allow large employers and multi-employer health plans to purchase coverage in the Exchange.

C.) Two federally regulated 'multi-state plan' (MSP) insurers, one being non-profit and the other being forbidden from providing coverage for abortion services, will be available in all states. They will have to oblige by the same federal regulations as required by individual state's qualified health plans available on the exchanges and must provide the same identical cover privileges and premiums in all states. MSPs will be phased in nationally, being available in 60% of all states in 2014, 70% in 2015, and 85% in 2016 with full national coverage in 2017.

January 1, 2018:

A.) All *existing* health insurance plans must cover approved preventive care and checkups without co-payment. No exceptions.

B.) A 40% excise tax on high cost "Cadillac" insurance plans is introduced. The tax is on insurance premiums in excess of $27,500 (family plans) and $10,200 (individual plans), and it is increased to $30,950 (family) and $11,850 (individual) for retirees and employees in high-risk professions. The dollar thresholds are indexed with inflation; employers with higher costs because of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

January 1, 2019:

Medicaid extends coverage for former foster care youths who are under 25 years old and were in foster care for at least six months during their lifetime.

January 1, 2020:

The Medicare Part D donut hole will be completely phased out and closed.

In the healthcare industry, most medical professionals are aware that the medical system has problems, but faith in the government fixing the problem is not strong. Most medical professionals are not confident that Obamacare is the answer to the problem. As stated by Marc Siegel in his article on Fox News “A new on-line survey by the non-profit, The Physicians Foundation, one of the largest doctors surveys ever performed, confirms that over two thirds of

physicians are pessimistic about the future of medicine, over 84 percent feel that our profession is in decline, and a majority would not recommend it as a career for their children. (The survey was sent to over 600,000 doctors and over 14,000 responded)". Most medical professionals feel they are already overburdened, underpaid, and ill equipped to handle their current caseloads, and they believe this will be increased with Obamacare and more insured Americans.

Public opinion of Obamacare is varied and often misunderstood by people. You can ask many people how they feel about Obamacare and they have an opinion, but if you ask them what Obamacare is they really cannot tell you. Very few people seem to have a good understanding of what Obamacare really is.

Ethical Issues for the Affordable Care ACT are some of the same issues we faced prior to the enactment of The Affordable Care Act. For instance, Obamacare does not provide any direct provisions that drive down healthcare costs, which has been a huge concern in medical care for many years. There is also no provision to change the current practice of defensive medicine that physicians are practicing. Also, the most abused insurers of fraud are the governments run Medicaid and Medicare programs so with the government oversight will fraud improve or increase? Our government complains of being broke in the Social Security Administration, the defense budget, the Medicare and Medicaid system…the list goes on. Therefore, another concern is whether they are capable of properly handling the business of medicine at all.

One area covered in the Affordable Care Act that will be beneficial to many people is the provision that insurers must cover pre-existing conditions without increasing premiums or excluding conditions. Another provision that has benefitted many Americans already was enacted on September 23, 2010; parents may keep their children on their insurance plan until

their 26th Birthday. Many other benefits are not well understood yet or are vague in description, which does not help.

Will the Affordable Care Act provisions improve or solve our current healthcare problems remains to be seen. Some people believe it will only increase the national deficit and current demand for health care professionals. Others believe it will improve care standards and reduce healthcare costs. Only as the provisions are implemented and track records become established will we know the answer to this current healthcare issue.

References

Charting the economy.com. (2009, April 8). *Healthcare expenditures as a % of gross domestic product* (World Health Organization Part 2). Healthcare Administration: Author.

Siegel, M. (2012, October 1). Why Obamacare has doctors depressed and discouraged. *Fox News*. Retrieved from http://www.foxnews.com/opinion/2012/10/01/why-obamacare-has-doctors-depressed-and-discouraged/

Wikipedia the free encyclopedia. (2013). In (Ed.), Wikipedia. Retrieved April 20, 2013, from http://en.wikipedia.org/wiki/Affordable_Health_Care_for_America_Act