

Patient Protection and Affordable Care Act

Fact Sheet

Access to Care

- Provides health insurance coverage for 32 million uninsured Americans by 2019.
- 23 million will remain uninsured, of whom one-third would be undocumented immigrants.
- 94 percent of legal nonelderly residents will be covered, up from 83 percent.
- Coverage will be expanded in two ways:
 - private-sector coverage
 - government-sponsored coverage
- Mandates individuals have coverage or face a tax penalty of the greater of \$695 per year up to a maximum \$2,085 per family or 2.5% of household income. The penalty will be phased-in over a three year period from 2014 to 2016. After 2016, the penalty will be increased annually by the cost-of-living adjustment.
- Provides government subsidies for those who can't afford the full cost of coverage in the form of premium tax credits and cost sharing assistance for individuals with incomes between 133% and 400% of the federal poverty level (that's \$29,327 and \$88,200 for a family of 4) to purchase insurance through the state insurance exchanges.
- New state health insurance exchanges will be created for the uninsured and small employers. These exchanges promote comparison shopping among standardized plans. Think of them like Travelocity or Orbitz for health care plans.
- States may form regional exchanges or allow more than one exchange to operate in a state as long as each serves a distinct geographic area.

Implications for Employers

- Essentially, the law penalizes large employers that do not provide health insurance coverage and incentivizes small employers to provide health insurance.
- Employers with 50 or more workers, will be fined if their employees purchase health care coverage through new exchanges and receive federal help to pay their premiums.
- Employers with 10 or fewer employees who earn, on average, less than \$25,000 a year can get a 50% tax credit for providing health insurance.
- Employers with 25 or fewer employees who earn, on average, less than \$50,000 can receive a partial tax credit.

Insurance Reforms

In 2010:

- All new plans will have no lifetime or annual benefit limits on coverage.
- Dependent children up to age 26 can remain covered under their parents' plans.
- Children with pre-existing conditions cannot be denied coverage.
- Coverage cannot be cancelled, except for nonpayment.
- High-risk insurance pools will be expanded for the uninsurable (individuals with pre-existing medical conditions who cannot otherwise get insurance).
- Insurers will be required to spend at least 80% of all premiums payments on medical services.

In 2014:

- Adults cannot be denied coverage because of pre-existing medical conditions.
- Limits will be placed on variations in insurance premiums with the following parameters:
 - 3:1 variation for age
 - Other permissible factors include geography, family size and tobacco use

Expansion of Public Programs

- Medicaid will be expanded in 2014 to children, pregnant women, parents and adults without dependent children under the age of 65 with incomes up to 133% of the Federal Poverty Level.
- The Medicaid expansion will be fully federally funded from 2014 to 2016 and decline to 95 percent in 2017, and 90 percent by 2020.

Workforce

- A multi-stakeholder Workforce Advisory Committee will be established to develop a national workforce strategy with appointments to be made by Sept. 30, 2010.
- The number of Graduate Medical Education training positions will be increased by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios. This provision is effective July 1, 2011.

- The workforce supply and support training of health professionals will be increased through the following.
 - scholarships and loans
 - support of primary care training and capacity building
 - state grants to providers in medically underserved areas
 - training and recruiting providers to serve in rural areas
 - establishing a public health workforce loan repayment program
 - providing medical residents with training in preventive medicine and public health
 - promoting training of a diverse workforce
 - promoting cultural competence training of health care professionals

- The projected shortage of nurses and retention of nurses will be addressed by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. The initial appropriation for this program will be in fiscal year 2010.

- Grants for up to three years will be provided to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. Funds are appropriated for five years beginning in fiscal year 2011.

Cost

- According to Congressional Budget Office analysis, the health reform law will cost \$940 billion over 10 years, but revenues exceed the costs, so it will reduce the deficit by \$127 billion.

- New sources of revenues:
 - Tax on high-income taxpayers
 - In 2018, tax on “Cadillac” health plans
 - \$67 billion from health insurers
 - \$33 billion from pharmaceutical companies
 - \$155 billion in reduced payments to hospitals for Medicare and Medicaid
 - Tax on medical devices, other than eyeglasses, hearing aids, etc.
 - Reduced payments to Medicare Advantage plans
 - 10% tax on tanning beds
 - Independent Payment Board with the authority to control Medicare payment rates
 - New and stronger fraud abuse programs
 - Higher income tax deductions for medical expenses
 - 7.5% to 10%, but seniors stay at 7.5% until 2016

Quality

- The law calls for the Health and Human Services Secretary to establish a national quality improvement strategy that includes priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency. These priorities apply to all patients, including children and vulnerable populations.
- The law applies a financial penalty to hospitals with readmission rates that are higher than expected.
- The legislation applies payment reductions for value-based purchasing in 2013, reducing payments to poor performers and giving money to good performers.
- Medical conditions acquired by patients in the hospital will not be paid.
- New delivery and financing models will be created to improve the traditional “fee-for-service” model including:
 - Bundled payments
 - Accountable Care Organizations
 - “Medical homes”

OTHER TOPICS

- Closes the “doughnut hole” of the Medicare Part D prescription drug coverage for seniors.
 - Provides a \$250 rebate to those who hit it in 2010
 - Increases subsidies to close the “doughnut hole” by 2020
- Requires health plans to cover preventive services, without cost sharing, as recommended by the U.S. Preventive Services Task Force, including immunizations and preventive care for infants, children and adolescents.
- Provides temporary government help to reduce the cost of employer-sponsored retiree coverage until the health insurance exchanges begin.
- Imposes new standards for assessing community health and the provision of community benefits by not-for-profit hospitals.
- Imposes new restrictions on not-for-profit hospital collections and the amount that may be billed to uninsured patients.
- Requires not-for-profit hospitals to have and publish a financial assistance policy.

SUMMARY OF POTENTIAL IMPACT

• Reduction in the number of uninsured

- Currently approximately 732,000 uninsured, or 14 percent of non-aged population.
- Expected reduction of 421,000 to about 8 percent of the non-aged population.

• Growth in Missouri Medicaid

- Expected growth of approximately 246,000 new participants.
- Some beneficiaries will shift to, or be jointly enrolled in, employer coverage.
- Costs of CHIP program are nearly “federalized” at 95 percent .
- Overall federal match rate grows from 65 percent to over 72 percent (average for medical care only).

• Impact on State Spending

- Some high-cost beneficiaries with intermittent coverage shifted to private insurance or migrate to the enhanced-match Medicaid expansion.
- Higher federal payments for expansion group (90 percent in 2020+) and CHIP (95 percent).
- Long-run impact on state spending is relatively small and depends on state choices.
- Substantial savings to the state during transition years (2014-2019) when the federal government funds between 93 percent and 100 percent of the Medicaid expansion.

**Kansas Hospital Association
Updated July 2010**