PolicyBrief

Georgia Health Policy Center

April 16, 2010

An Overview of Health Reform

This policy brief takes a look at the Patient Protection and Affordable Care Act (Health Reform) in the United States and specifically looks at a comparison for the state of Georgia. The first in a series, the policy brief package will also include the following communications: State Implications, Community Implications, and the Provider Impact. Other topic-specific information may be provided to further educate and prepare for the transition.

CHANGES TO PUBLIC HEALTH INSURANCE

By 2019, as many as 16 million more people may be insured through Medicaid and the Children's Health Insurance Program (CHIP) as a result of the new health reform law.* Changes to public health insurance will also affect Medicare, Indian Health Services, and the U.S. Department of Veterans Affairs. The new legislation attempts to address certain aspects of each public program, including access, enrollment, benefits, prescription drug coverage, quality and efficiency of services offered, options for long-term care resources and supports, and funding to hospitals caring for a disproportionate share of the uninsured. The law includes temporary and long-term provisions with some elements enacted immediately and then phased out, and others enacted on a delayed timeline. The major changes to public health insurance coverage outlined in the law can be viewed in three categories: expanded and coordinated eligibility, expanded services offered, and changes to payment mechanisms.

ELIGIBILITY

- Beginning in 2014, extends Medicaid coverage beyond qualified children, their caretakers, pregnant women, the disabled, and certain other groups to cover all individuals under the age of 65 who are at or below 133% of the federal poverty level.
- Continues the Children's Health Insurance Program and allows states to expand eligibility.
- Improves coordination for individuals eligible for both Medicaid and Medicare.

SERVICES OFFERED

- Offers new and expanded services and funding options for special populations including American Indians and Alaska Natives, maternal and child populations, and long-term and elder care:
  - Gives states the option of extending Medicaid coverage to family planning services.
  - Covers tobacco cessation for pregnant women through Medicaid.
  - Covers evidence-based prevention programs through Medicare.
  - Creates a national, voluntary long-term care insurance program. Premiums will be deducted from every worker's paycheck unless they choose to opt-out.
- Extends Medicaid coverage of prescription drugs through benchmark benefits, rebates, and requirements to cover specific drugs.
- Offers a temporary provision of a $250 rebate for those who reach the Medicare Part D "donut hole."

PAYMENT MECHANISMS

- Beginning in 2014 and 2016, respectively, enhances federal payments to states for Medicaid and CHIP for expansion populations.
- Temporarily increases Medicaid payments for primary care services.
- Requires Medicare Part D enrollees above a certain income to pay higher premiums.

**Estimated by the Congressional Budget Office, March 20, 2010.*

CHANGES TO PRIVATE HEALTH INSURANCE

Changes in the private health insurance market impact insurers, employers, individuals and families. A key provision in the law is that health insurance companies will be able to contract with a government agency or non-profit organization to participate in a health insurance exchange. The exchange will allow businesses and individuals to select from a range of insurance plans. All plans must offer coverage for essential benefits, which include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care). Other changes include new rules in the insurance market that

aim to increase participation in health plans by expanding eligibility, offering protections against loss of eligibility, improving the quality of services, and expanding choices for insurance coverage.

INSURERS

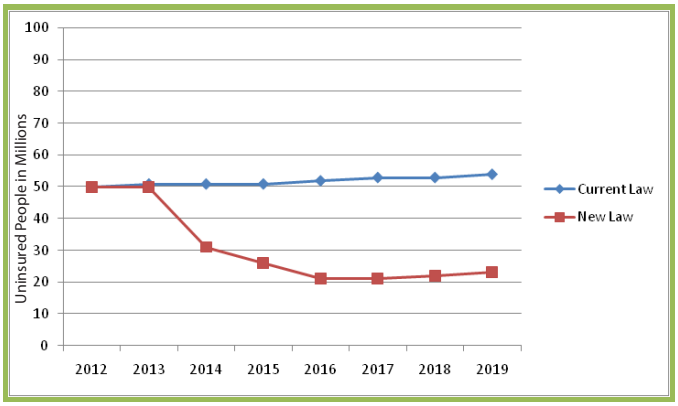
- Requires states to create health insurance exchanges by 2014. There will be two types of exchanges, individual and Small business Health Options Program (SHOP), although states may combine exchanges or propose a state-specific alternative. The individual exchange will be open to individuals who do not have qualifying coverage through an employer or a public program. SHOP will be open to individuals and employers with less than 100 employees.
- Bans lifetime coverage limits, meaning there is no limit on what an insurer must pay for the life of the insurance policy. Coverage cannot be cancelled except in cases of fraud, and beginning in 2010 children cannot be excluded due to pre-existing conditions. By 2014, coverage cannot be denied for adults with pre-existing conditions.
- In 2010, institutes a temporary, national high-risk pool for those previously unable to obtain insurance due to poor health.
- In 2016, permits insurers to sell products across state lines through established health care choice compacts.

EMPLOYERS

- Provides tax credits to small businesses. Effective 2010, this provision will apply to employers of 25 employees or less with average wages of less than $50,000 who offer coverage that meets minimum requirements.
- Establishes a temporary re-insurance program so that employers providing health insurance coverage to retirees, ages 55-64, may receive financial assistance to offset early retiree claims between $15,000 and $90,000.

The Trend of the Uninsured in the United States:

*Current Law Compared to Patient Protection and Affordable Care Act***



***Based on estimates by the Congressional Budget Office. Data was adapted after the reconciliation and shows the non-elderly uninsured including unauthorized immigrants.*

- In 2014, assesses a fine to businesses with more than 50 workers if they do not offer coverage and have at least one employee receiving a tax credit through an exchange.

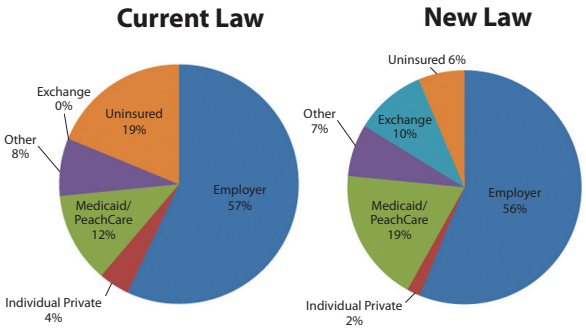
INDIVIDUALS AND FAMILIES

- By 2014, requires all individuals to obtain health insurance or pay a penalty, although some exceptions will apply. The penalty, in the form of a tax, will first be assessed as 1% of household income, moving to 2.5% in 2016 and beyond. There will be upper income limits and those who can show financial hardship or have religious reasons may be exempt.
- In 2010, allows unmarried children up to age 26, regardless of full-time student status, to stay on a parent's plan unless offered a choice of plans by their own employer.
- Effective 2014, offers tax credits on a sliding scale for families below 400% of the federal poverty level (FPL) to offset premiums and help with out-of-pocket costs for insurance purchased in the exchanges. (In 2010, 400% FPL for a family of four is about $88,000/year.)

The expansion of both sectors, public and private, is expected to insure approximately 32 million more Americans by 2019.*** Georgia is ranked as 5th highest in the number of uninsured individuals in the U.S. In 2008, the number of Georgians without health insurance was 1.67 million.+ The expected changes in private and public coverage are depicted below++:

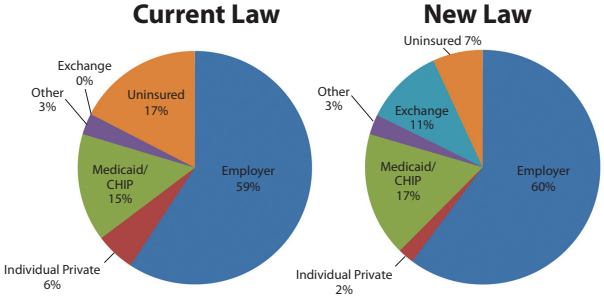
Sources of Coverage in Georgia:

Before and After Full Implementation of Health Reform



Sources of Coverage in the United States:

Before and After Full Implementation of Health Reform



****Estimated by the Congressional Budget Office, March 20, 2010.*

+Custer and Ketsche, Institute of Health Administration, Robinson School of Business, Georgia State University

++This shows the non-elderly and is a preliminary estimate, subject to revision.

IMPROVING HEALTH CARE QUALITY

The new health reform law includes several provisions intended to improve the quality of care in the U.S. health care delivery system. One strategy to improve quality includes incorporating best practices and systematically collecting and analyzing health care data. A second strategy involves streamlining and coordinating care, as well as encouraging interdisciplinary treatments. One example of the integration of a health system is accountable care organizations (ACOs), which will encourage physician groups to join together to gain efficiencies, improve quality of care, and reduce spending. A third strategy involves a series of quality-driven incentives and penalties for providers. Additional quality-related elements of the new legislation include funding to study and implement evidence-based practices related to the financing and delivery of Medicare and other forms of health care finance.

BEST INFORMATION

- Supports the use of practices that improve the quality, safety, and efficiency of health care delivery.
- Creates a uniform strategy to collect and analyze data from existing health care information systems that relate to health care quality and use. Performance and quality data must be available to the public through standardized Internet websites.

COORDINATED AND INTERDISCIPLINARY CARE

- Improves quality and reduces cost of chronic disease treatment through funding for medication management and by encouraging medical professionals to collaborate.
- Funds community-based health care teams to support primary care practices, including obstetrics and gynecology practices.
- Establishes a primary care extension program to provide support and educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based therapies and techniques.
- Awards grants to states to establish extension program hubs to coordinate state health care functions with quality improvement organizations and area health education centers.

PROVIDER PAYMENT INCENTIVES AND PENALTIES

- Assesses a Medicare rate penalty for hospitals with high rates of hospital-acquired conditions, could influence Medicaid rates as well.
- Establishes a hospital value-based purchasing program where incentive payments are made to hospitals that meet specified performance standards.
- Offers incentives and penalties designed to encourage physicians to participate in a quality reporting system.

IMPROVING HEALTH

Efforts to improve health and well-being will be coordinated by a national council, supported by research and innovation, and implemented through insurance coverage requirements and state and community programs. Wellness and prevention services and research will be expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation and other chronic disease priorities. Public and private insurers will be required to provide preventive and wellness services in their qualified health plans, and employers will be permitted to incentivize employee participation in wellness programs. State and local agencies will be given opportunities to apply for federal funds to implement programs to create healthier communities.

INTEGRATIVE NATIONAL HEALTH STRATEGY

- In 2010, creates a National Prevention, Health Promotion & Public Health Council comprised of leadership across federal departments and agencies.
- Develops by 2011 a national blueprint for improving federal prevention, health promotion, public health, and health care practices.

RESEARCH AND PUBLIC HEALTH INNOVATION

- Supports data collection on race, ethnicity, sex, primary language, disability, rural and frontier geographic status as a way to identify and monitor health disparities.
- Promotes research that examines best practices and cost effective strategies for organizing, financing and delivering preventive health services.
- Funds oral health promotion and research to include school based dental-sealant programs, initiatives to improve oral health surveillance and data collection, and effectiveness research of dental disease management programs.

MEDICAID AND MEDICARE PREVENTIVE SERVICES

- By 2011, provides Medicare beneficiaries wellness services and access to personalized prevention plans.
- Implements and evaluates state initiatives that incentivize risk and behavior modification among Medicaid beneficiaries.

HEALTHIER COMMUNITIES

- Awards Community Transformation Grants, beginning in 2010, to states, local government, and community-based organizations to use, evaluate, and communicate evidence-based practices.
- Provides pilot grants to communities in 2010 for screenings, interventions, and clinical referrals for 55-64 year olds and those 65 and older.
- In 2011, gives grants to small employers to establish workplace wellness programs.
- Requires nutritional content to be displayed in vending machines and chain restaurants with 20 or more locations. Menus must also mention the suggested daily caloric intake.

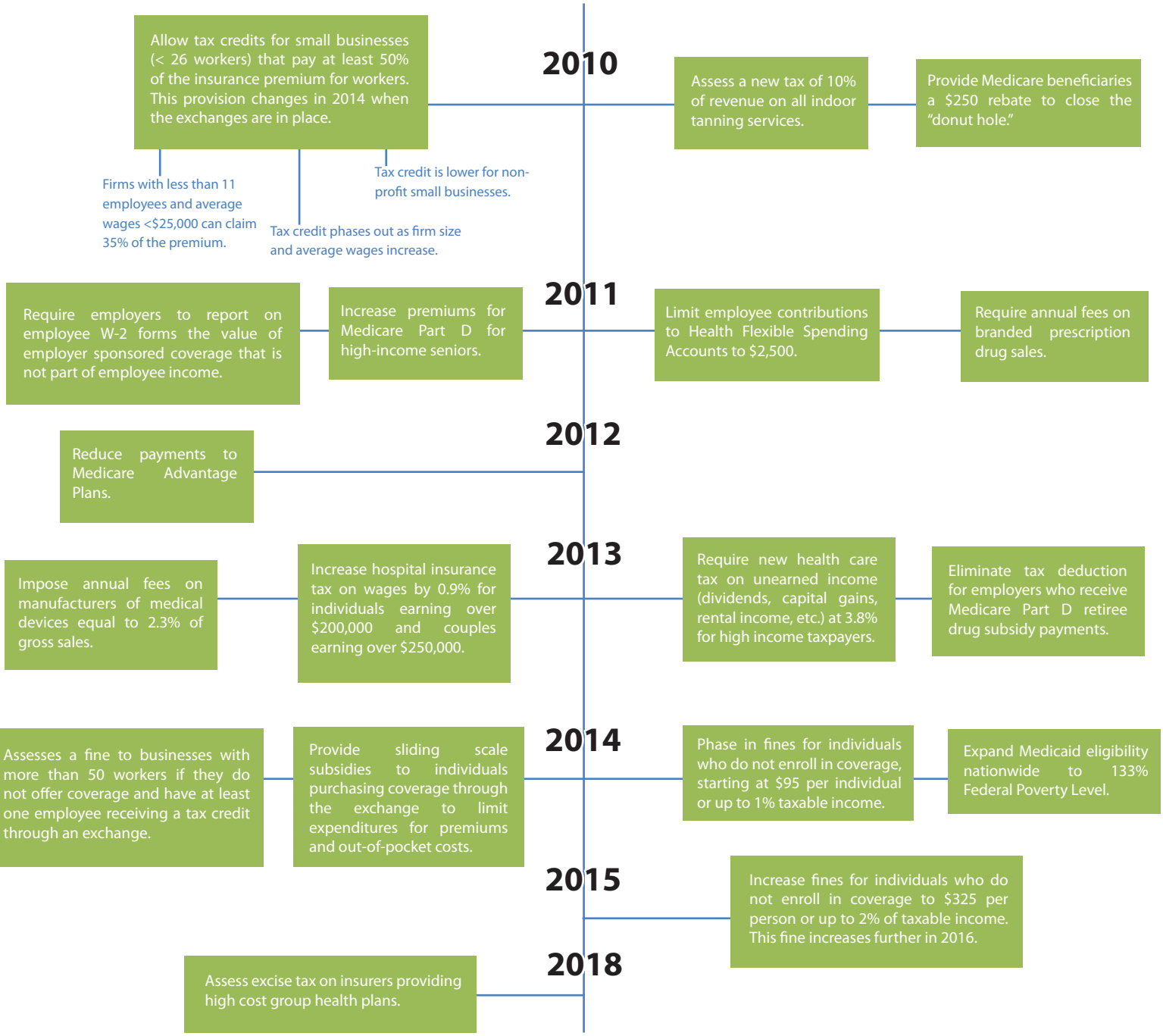
Note: Information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Many details will be solidified and may change.

COST AND FUNDING

The Congressional Budget Office (CBO) estimates that the total new cost to the federal government for this reform will be about $940 billion over the next decade. The largest portion of those costs will fund the expansion of Medicaid coverage ($434 billion) and fund the subsidies in the health insurance exchanges ($465 billion). The CBO also estimates that the new federal spending will be offset by a combination of taxes and savings from changes to the Medicare program. Some of the new taxes include:

- Increased Medicare taxes on high income earners (individuals less than $200,000 or families less than $250,000 annual income).
- Payments from businesses and individuals who do not offer or take up coverage.
- New taxes on medical devices manufacturers, pharmaceutical companies, and health insurance companies.

SIGNIFICANT FEDERAL FINANCIAL IMPLICATIONS



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