

Medical Students Guide to the Health Care Reform Law

Introduction

As medical students, our busy schedules often make it difficult to remain informed about changing social and political issues. However, the magnitude and importance of some developments require our utmost attention. The new health care reform law is one such crucial issue.

In March 2010, the Patient Protection and Affordable Care Act was signed into law. It was amended shortly after through the reconciliation process and the final version is now referred to as the Affordable Care Act (ACA). Many of the components of this law have already taken effect and the rest are on the way through 2014 and beyond. Whether one agrees or disagrees with any or all parts of the act, the undeniable fact is that, as future physicians, the consequences of this law will have a great impact on the way we will practice medicine and how our patients will access health care services. Thus, it is important for us to be fully acquainted with the new law, not only because of its effects on our future practice, but because of our obligation to educate and assist our patients in accessing the health care services they need. In the politically-charged media we all are exposed to, it is often difficult to find the unadulterated facts about health care reform. Even now, almost one year after enactment of the ACA, a large percentage of medical students are unfamiliar with the major provisions of this law and unaware of the various sources of information available to them. Therefore, the Council of Student Members (CSM) of the American College of Physicians (ACP) decided to outline the major provisions of the ACA in this guide which is designed specifically for medical students. This guide will also provide various sources, which the authors believe deliver unbiased information regarding the law.

Although this guide is mainly focused on facts, it is important to note that any opinions expressed or implied belong solely to the authors and in no way represent the position of the ACP or the CSM as a whole. Additionally, the actual law is close to 1,000 pages so in order to create a practical guide we have only included what we believe to be the major provisions of this law and in no way shall this guide be interpreted as an exhaustible list of all provisions and sources. We encourage all readers, especially medical students, to use the provided and other available resources to learn more about the details of this law.

Major Provisions

Some health insurance plans are exempted from some of the provisions of the ACA. These plans are collectively referred to as the “Grandfathered Health Plans” and generally include policies that existed on or before March 23rd, 2010. Although we encourage all of our readers to explore the differences between exempted and non-exempted plans through the provided and/or other resources, this article focuses on policies that do not have such exemptions.

Expanding Health Insurance Coverage

One of the major goals of the health reform movement was to achieve universal health insurance coverage. It should be noted that the ACA does not achieve this goal but is expected to expand coverage to 32 million currently uninsured individuals. An estimated 23 million, or 8% of the population, will still remain uninsured, which is largely composed of individuals who lack legal immigration status who will be ineligible for any of the health reform benefits. As discussed below, the ACA expands coverage through new rules, incentives, tax credits and supplements as well as expansion of federal insurance programs.

New Rules for Insurance Providers:

The ACA prohibits insurance providers from charging significantly higher premiums and/or excluding, limiting or denying coverage based on pre-existing conditions. In September 2010 these protections became effective for all children under the age of 19 and will be extended to include all individuals in 2014 when the law is scheduled to be fully implemented. Also, in July 2010, a “Pre-existing Condition Insurance Plan” was created to fill the gap until the date of full implementation.

Furthermore, the ACA requires all insurance plans to allow young adults under the age of 26, regardless of current occupation, residence or marital status, to be covered under their parents’ health insurance plan(s) if they wish to do so.

There are other new rules that affect insurance providers which do not necessarily expand coverage and will be discussed with Patient Protection Measures subsection below.

New Rules for Employers and Individuals:

The new rules for employers and individuals are perhaps the most controversial requirements of the new law and will both take effect in 2014.

Starting with the 2010 tax year, employers with less than the equivalent of 25 full-time workers who meet other requirements may be eligible for tax credits if they elect to offer health insurance to their employees. It must be noted that eligibility requirements changes for such tax credits in subsequent years. Beginning in 2014, employers with greater than 50 employees will be required to offer health insurance or face penalties. Employers with less than 50 employees are exempted from this requirement.

Also starting in 2014, individuals who are not covered by their employer, a family member’s plan or a federal insurance program will be required to purchase health insurance. Individuals who are unable to afford comprehensive coverage, people with religious objections, American Indians, among others, are exempted from this requirement. Subsidies will be provided to those with incomes between 133%-400% of the poverty level. Those below 133% of the poverty level will be eligible for Medicaid as explained below. Individuals who choose not to purchase health insurance will have to pay a fine imposed by the Internal Revenue Service (IRS).

Expansion of Federal Insurance Programs:

Another measure in the ACA aimed at decreasing the number of uninsured is the expansion of existing federal programs, namely Medicaid. As mentioned above, the eligibility income level for Medicaid will be set at 133% of the poverty level for all individuals, not just women and children, starting in 2014. States will receive 100% federal funding for the increased coverage from 2014 to 2016 after which the federal funding will gradually decrease to 90% in 2020 and will remain at that rate thereafter. In 2013 and 2014, reimbursement rates for certain primary care services provided under Medicaid will also be increased to match Medicare rates with 100% federal funding for the additional liability.

The ACA will also require states to continue the Children's Health Insurance Program (CHIP) through 2019 and will increase the CHIP federal match rate to 100% after 2015.

Increasing Patient Protections and Choices

After increasing coverage, reform of the health insurance market by enhancing patient protections and increasing consumer choice is the second biggest goal of the ACA. These changes will affect private insurers, federal programs and newly created health insurance exchanges.

Changes affecting Private Insurance Companies:

The ACA also limits rescission of coverage and prohibits lifetime limits on the dollar value of coverage. In 2014, annual dollar limits for coverage will be removed as well.

However, one of the provisions that will affect most policyholders is the requirement for annual reviews of premiums and the medical loss ratio clause. Since 2010, the ACA has provided financial assistance to states to review premiums and requires insurance companies to justify any substantial premium increases. Beginning in 2011, insurance companies will also have to publicly report their medical loss ratio, or the amount actually paid for health services and quality of care improvements as a percentage of premium dollars and rebate customers if such ratio is less than 80-85%, depending on the market. This will increase market transparency and will limit profits and administrative costs to less than 15-20%.

Changes affecting Federal Programs:

Federal programs will also be reformed starting with Medicare. The Medicare Part D prescription drug coverage "donut hole" will begin to be closed in 2010. Currently, when a covered individual has accumulated around \$2,700 in prescription benefits, the insured becomes fully responsible for the cost of the prescriptions until reaching the catastrophic coverage limit which is set at around \$6,100. There are various initiatives within the ACA which aims to reduce the burden of this gap on Medicare patients which became effective in 2010 and eventually this coverage gap will cease to exist after 2020.

The ACA will also expand Medicare coverage to those who have developed health conditions after being exposed to environmental hazards while living in a disaster area.

Also, under the new law, dual eligibles, those eligible for both Medicare and Medicaid, will benefit from improved care coordination and resources will be devoted to cutting waste, fraud and abuse from both programs.

Increasing Consumer Choice:

As of July 2010, as required by the ACA, the government has taken steps to make the process of buying health insurance simpler. The first step was to create a federally administered website where consumers can compare health insurance options. Work has also begun to develop standards for providing information on benefits and coverage in order to facilitate consumer's understanding of benefits and covered services.

These rules would also apply to any plan that participates in new state-based insurance exchanges, which are to serve as transparent and competitive markets for small businesses and individuals without employer-based insurance which will be established in 2014. Exchange-based plans will have to comply with one of four benefit categories. Insurance plans offered through the exchanges must meet the requirements of an essential health benefits package to be set forth by the Secretary of Health and Human Services.

These exchanges will also offer non-profit consumer-operated and oriented plans (CO-OPs) funded by the ACA. States may also choose to form health care choice compacts that would allow for insurance companies to sell plans across state lines in any of the participating states and through their exchanges.

Delivery System Changes and Primary Care

Many of the provisions discussed under this subsection could easily be classified under the cost-containment subsection but also aim to improve quality and performance of the health system. The basic theme amongst these changes is that they are introduced in the Medicare/Medicaid programs and aim to serve as practical models for private insurers to follow.

The ACA authorized formation of the Center for Medicare and Medicaid Innovation to help the Department of Health and Human Services develop a national quality strategy. They will start by establishing a hospital value-based purchasing program in Medicare to pay bonuses to hospitals based on quality measures in 2012. This will be followed by demonstration projects through Medicare and Medicaid to pay bundled payments for episodes of care that include hospitalizations. Concurrently, physician and hospital groups that form accountable care organizations (ACOs) will be eligible to share in savings they create and the Patient-Centered Medical Home Model (PCMH) pilots will be expanded. Medicare has also been funded to complete a demonstration project called Independence at Home for home-care delivery.

These changes in health care delivery, center on primary care and prevention so the ACA has included provisions that aim to promote preventive medicine and increase the primary care workforce. Beginning in 2010, a \$15 billion Prevention and Public Health Fund will begin investing in proven national

programs, including the National Health Service Corps, community health centers and rural health care providers.

Beginning in 2011, private insurance plans as well as Medicare can no longer charge any additional fees (e.g. co-payments) for the cost of preventive services, such as routine immunizations and cancer screening tests, as outlined by the United States Preventive Services Task Force (USPSTF).

ACA also guarantees that insured individuals can choose any primary care doctor, including pediatricians, within their health plan's provider network and visiting an in-network Ob-Gyn specialist can no longer require prior referral from another physician. Furthermore, the ACA bars health plans from requiring higher fees or prior approval for seeking out-of-network emergency department services.

From 2011 through 2015, qualified primary care physicians will receive a 10% Medicare bonus and employers can apply for grants to establish wellness programs for their employees. Beginning in 2014, employers will be allowed to offer their employees rewards up to 30% of the cost of coverage for participating in wellness programs.

Cost Containment

In order to pay for the provisions outlined above, which expand coverage, increase patient protections and access, and pay for prevention, the cost of health care delivery had to necessarily be decreased. Many of the cuts that were made will affect payments and premiums of federal insurance programs but private insurers will also be affected through taxes and other limitations aforementioned. Medicare will reduce the annual payment updates to hospitals, skilled nursing facilities, home health and other Medicare providers and Medicaid will reduce disproportionate share hospital payments (for safety net hospitals) in 2011. Medicare will stop paying for excess hospital re-admissions and both programs will stop paying for hospital-acquired infections. Medicare will also increase Part B premiums for those beneficiaries with the highest incomes. Beginning in 2014, a newly formed Independent Payment Advisory Board will recommend further Medicare savings proposals if spending exceeds a target growth rate based on inflation and gross domestic product. This board is prohibited from recommending proposals that would ration care, modify benefits, eligibility, premiums, raise taxes or reduce payments for certain providers.

One of the biggest savings in the law will affect private insurers that contract with the government through the Medicare Advantage program. Through different avenues, Medicare will eventually decrease the amount that is paid to these programs over traditional Medicare but will offer bonuses to those plans that receive high quality ratings. In addition to the above constraints put on the private insurance system, the health insurance sector and the pharmaceutical sector, will face increased annual tax fees. Estimated to raise \$32 billion over 10 years, an excise tax will be created for the most expensive health plans, also known as "Cadillac plans". Medical devices and indoor tanning will be taxed as well. By 2014, health insurance plans will have to comply with a set of standards designed to simplify administration and reduce costs.

Miscellaneous

- The ACA will address long term care through formation of a national, voluntary insurance program for purchasing Community Living Assistance Services and Supports (CLASS) and through Medicaid funded incentive programs to increase state-based long term care services.
- For retirees who do not meet the age requirement for Medicare, the ACA has created a reinsurance program that reimburses employers 80% of these retirees' health insurance costs.
- The new law also allows for generic availability of biologic drugs after 12 years of exclusivity for the original manufacturers.
- Medical malpractice demonstration projects will fund states to evaluate alternatives to current tort litigation.
- Full financial disclosure will be required between hospitals, health providers and drug or device manufacturers.
- The ACA requires chain restaurants and vending machines to display nutritional content of the foods they sell.
- Patient Centered Outcomes Research Institute will be formed to identify research priorities for comparative effectiveness research. The law explicitly prohibits the outcomes of such research from being construed as mandates, guidelines or recommendations for payment, coverage or treatment.
- The ACA, following the precedent of current federal laws, outlines that federal funds may not be used for abortion services except in cases where the life of the woman would be endangered or in cases where the pregnancy is the result of an act of rape and/or incest.

Available Resources

Government Sources

Library of Congress (www.thomas.gov):

- Full text of the law is available on this site for your reading pleasure.

HealthCare.gov (www.healthcare.gov):

- Great resource for quick and concise facts about the law which may be utilized by all sectors of the society including patients, health care providers and employers.
- Also, provides valuable information regarding available plans and resources.
- *Caution: This is a government website managed by the U.S. Department of Health and Human Services and provides factual information about the law but may lack opposing views.*

White House (www.whitehouse.gov/health-care-meeting):

- Contains a detailed summary of the key provisions of the ACA as well as the potential negative outcomes of its repeal.
- *Caution: This is a government website managed by the White House and may currently have some bias favoring the views of the Democratic Party.*

House Republican Conference (www.gop.gov):

- Provides details regarding the Republican party's position on various issues including health care reform.
- *Caution: This is a government website managed by the House Republican Conference and contains bias favoring the views of the Republican Party.*

Independent Sources

Kaiser Family Foundation Health Reform Section (www.healthreform.kff.org):

- Private, non-partisan, non-profit foundation dedicated to health care issues.
- Provides access to various interactive resources including timelines, summary documents and news.
- Furthermore, the foundation offers multitude of research data regarding the past and current state of health care in the United States as well as projections regarding the positive and negative effects of the ACA.

KaiserEDU.org (www.kaiseredu.org):

- Another resource from Kaiser Family Foundation specifically designed for students and faculty in health policy and related disciplines.
- This site provides more detailed information regarding various health care issues including the health care reform law.
- Due to the complexity of the presented information, this resource is more appropriate for health care professionals.

RAND Health COMPARE (www.randcompare.org):

- Non-profit research organization providing sophisticated analysis of the law.
- Incorporates microsimulation models to predict the impact of the ACA on different sectors of the society.
- Also, offers alternative options and models for health care reform.

FactCheck.org (www.factcheck.org):

- Nonpartisan, nonprofit consumer advocacy group sponsored by the Annenberg Public Policy Center of the University of Pennsylvania.
- Great resource for reaffirming factual accuracy of the information obtained from unreliable or biased sources.

Physician-Led Organizations

American College of Physicians (ACP) Advocacy Center (www.acponline.org/advocacy):

- Outlines the official positions of the ACP regarding the ACA as well as various other health care related laws, regulations and policies.
- This website is a great resource for internists and aspiring internists to learn about what the ACP has identified to be the key issues facing the health care system and how the largest specialty college in the United States is planning to resolve such issues.

American Medical Association (AMA) Health System Reform (www.ama-assn.org/go/reform):

- Provides news and resources regarding the health system reform.

American Osteopathic Association (AOA) Advocacy Site (www.osteopathic.org/advocacy/):

- Outlines the official positions of the AOA regarding the ACA as well as various other health care related laws, regulations and policies.

Conclusion

In conclusion, we hope this guide fairly represented the major provisions of the health care reform law, provided a basic background about the new initiatives, introduced comprehensive sources of information and motivated you to become more active in policy-making. We fully recognize that the ACA is not perfect and more work is needed in order to fully address the access and quality barriers facing our health care system. We invite all medical students to join the CSM and the ACP in promoting initiatives aimed at increasing the primary care workforce and improving primary care delivery through innovative models, such as the Patient-Centered Medical Home (PCMH) and debt-repayment programs for practicing in primary care fields.

Sources:

www.healthcare.gov

www.irs.gov

www.healthreform.kff.org

Amirala S. Pasha

New England Region Representative, Council of Student Members, American College of Physicians
University of New England, College of Osteopathic Medicine, 2012

Email: apasha@une.edu

Justin Taylor

Southwestern Region Representative, Council of Student Members, American College of Physicians
University of New Mexico, 2011

Email: jutaylor@salud.unm.edu