LEARNING OBJECTIVES

The student will be able to:
- List and summarize the 10 major provisions of the Patient Protection and Affordable Care Act of 2010.
- Evaluate the impact of the ACA on accessibility of healthcare plans to individuals and small businesses.
- Discuss the impact of the ACA on the health insurance industry.
- Describe the impact of the ACA on public health programs.
- Define and discuss the Health Insurance Marketplace.
- List and describe the essential health benefits required by the ACA for health insurance plans.

DID YOU KNOW THAT?

- The ACA requires most U.S. citizens and legal residents to purchase health insurance if they can afford it or pay a penalty.
- The ACA mandates that every state create a consumer-oriented marketplace where individuals are provided information and can purchase healthcare insurance.
- The ACA bans new health plans from establishing lifetime dollar limits on most healthcare insurance reimbursement.
- The new Independence at Home program provides an opportunity for the chronically ill to be treated at home.
- The ACA established the Medicare and Medicaid Innovation Center, which provides opportunities for innovative healthcare research.
- The Elder Justice Act, passed as part of the Affordable Care Act, targets abuse, neglect, and exploitation of the elderly.
Introduction

The Patient Protection and Affordable Care Act (PPACA), or as it is commonly called the Affordable Care Act (ACA), and its amendment, the Healthcare and Education Affordability Reconciliation Act of 2010, were signed into law on March 23, 2010, by President Barack Obama. The goal of the act is to improve the accessibility and quality of the U.S. healthcare system. There are nearly 50 healthcare reform initiatives that are being implemented during 2010–2017 and beyond. The passage of this complex landmark legislation has been very controversial and continues to be contentious today.

There were national public protests and a huge division among the political parties regarding the components of the legislation. People, in general, agreed that the healthcare system needed some type of reform, but it was difficult to develop common recommendations that had majority support. Criticism focused in part on the increased role of government in implementing and monitoring the healthcare system. Proponents of healthcare reform reminded people that Medicare is a federal-government entitlement program because when individuals reach 65 years of age, they can receive their health insurance from this program. Millions of individuals are enrolled in Medicare. Medicaid is a state-established governmental public welfare insurance program based on income for millions of individuals, including children, that provides health care for its enrollees.

However, regardless of these two programs, many critics felt that the federal government was forcing people to purchase health insurance. In fact, the ACA does require most individuals to obtain health insurance only if they can afford it. But with healthcare system expenditures comprising 17.9% of the U.S. gross domestic product and with millions of Americans not having access to health care, resulting in poor health indicators, the current administration’s priority was to create mandated healthcare reform.

Legal Issues with the Affordable Care Act

The goal of the act is to improve the accessibility and quality of the U.S. healthcare system. There are nearly 50 healthcare reform initiatives that are being implemented over several years. As discussed earlier, the main bone of contention is the requirement of the act that U.S. citizens and legal residents must purchase health insurance or pay an annual fine for non-compliance. As a result of this mandate, over 20 states filed lawsuits, primarily questioning the constitutionality of this mandate. The second major contentious issue is whether Medicaid expansion requirements were constitutional because the federal government could withhold federal Medicaid funding to states that refuse to expand their Medicaid programs. Finally, the third contentious issue was requiring all businesses to offer health insurance coverage for contraception as part of their employee benefits. There was issues with this mandate because some religiously oriented businesses did not believe in certain components of the contraceptive mandate.

On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the ACA in a 5–4 ruling in the Florida v. Sebelius lawsuit regarding individual health insurance mandates and the National Federation of Independent Businesses v. Sebelius lawsuits filed regarding Medicaid expansion (ProCon.org, 2016a). However, the federal government could not withhold federal funding to states that refuse the Medicaid expansion because it could be considered coercion. As a result of this decision, the federal government was required to develop state incentives to accept the Medicaid expansion and to restrict the type of funding limitations to states that refuse the Medicaid expansions (Svendiman & Baumrucker, 2012).

On June 30, 2014, in the Hobby Lobby and Conestoga vs. Sebelius decisions, the Supreme Court ruled that the federal government cannot mandate that religious organizations provide, as part of their employee benefits, drugs or devices that end human life. Both Hobby Lobby and Conestoga Wood Specialties Corp. did not object to the entire contraceptive mandate but did object to that specific mandate.

On June 25, 2015, the Supreme Court ruled in favor of the Affordable Care Act. In King v. Burwell, by a vote of 6–3, the Supreme Court rejected a challenge brought on grounds that financial assistance should be given only to individuals who purchased health insurance via the federal marketplaces. The federal government argued that subsidies were available to all individuals who purchased health insurance via all marketplaces, both federal and state run.

The challengers were four residents of Virginia who did not want to purchase health insurance because they could not afford it. They resented the federal government mandate of requiring to purchase health insurance. They said they could not afford it but would have to purchase it, if the subsidies were available. If the subsidies ruling was overturned, there would have been 8 million individuals who would have lost their health insurance because they could not afford it otherwise (Ehrenfreund, 2015).
In January 2016, Congress enacted a repeal of the ACA’s major provisions which the President vetoed. However, there has been a House of Representatives special task force assembled to develop a replacement for the ACA. Depending on the November 2016 elections that could impact what will occur with the ACA provisions.

On May 13, 2016, the Department of Health and Human Services issued final regulations on section 1557 of the ACA. The rule emphasizes that healthcare discrimination against LGBTQ individuals, particularly transgender and gender non-conforming people, is against federal law. Section 1557 provides protection based on race, color, national origin, sex, age, and disability. LGBT protection falls under sex discrimination. This rule applies to facilities that receive federal assistance, every federal program administered by the DHSS and programs under Title 1 of the ACA which includes hospitals, clinics, pharmacies, labs, and HIV testing sites nationally. This also includes most types of health insurance plans (Transgender, 2016).

Major Provisions of the Affordable Care Act

**TABLE 2-1** provides an updated summary of the over 40 major action items of the ACA (Centers for Medicare & Medicaid Services [CMS], 2013c). The key features of the law include rights and protection of healthcare consumers, insurance choice and insurance costs, benefits for those 65 and older, and employer requirements of providing healthcare benefits. The law itself is divided into 10 titles or areas of healthcare reform. This chapter will provide a summary of each title and an update on the implementation of these areas of healthcare reform. It is important to note that certain health insurance plans can be grandfathered plans which means they do not have to follow the rules and regulations of the ACA. These grandfathered plans are plans that were purchased before March 23, 2010. This means that on many old plans you can still be dropped from coverage for reasons other than fraud,

**TABLE 2-1 Timeline for Affordable Care Act Regulations**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Affordable Care Act Signed into Law</td>
</tr>
<tr>
<td></td>
<td>States to Increase Medicaid Coverage</td>
</tr>
<tr>
<td></td>
<td>One time $250 Rebate for Medicare Part D Donut Hole</td>
</tr>
<tr>
<td></td>
<td>Target Healthcare Fraud</td>
</tr>
<tr>
<td></td>
<td>Early Retiree Reinsurance Program (ERRP)</td>
</tr>
<tr>
<td></td>
<td>Insurance for Preexisting Conditions</td>
</tr>
<tr>
<td></td>
<td>Online Information for Healthcare Consumers at <a href="http://www.healthcare.gov">http://www.healthcare.gov</a></td>
</tr>
<tr>
<td></td>
<td>Extend Age for Young Adults’ Coverage to 26</td>
</tr>
<tr>
<td></td>
<td>Prohibit Insurance from Dropping Coverage</td>
</tr>
<tr>
<td></td>
<td>Appeal of Insurance Coverage Denials</td>
</tr>
<tr>
<td></td>
<td>Eliminate Lifetime Limits on Insurance Coverage</td>
</tr>
<tr>
<td></td>
<td>Regulate Annual Limits on Insurance Coverage</td>
</tr>
<tr>
<td></td>
<td>Ban of Coverage Denial of Children with Preexisting Conditions</td>
</tr>
<tr>
<td></td>
<td>Accountability of Insurance for High Rate Hikes</td>
</tr>
</tbody>
</table>

(continues)
### TABLE 2-1 Timeline for Affordable Care Act Regulations (continued)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Prescription Drug Discounts</td>
</tr>
<tr>
<td></td>
<td>Free Preventive Care for Seniors</td>
</tr>
<tr>
<td></td>
<td>Reduce Healthcare Premiums</td>
</tr>
<tr>
<td></td>
<td>Strengthen Medicare Advantage</td>
</tr>
<tr>
<td></td>
<td>Improve Quality and Efficiency of Health Care</td>
</tr>
<tr>
<td></td>
<td>Improve Senior Care After Discharge from Hospital</td>
</tr>
<tr>
<td></td>
<td>Innovation to Reduce Costs</td>
</tr>
<tr>
<td></td>
<td>Increase Home and Community Health Services</td>
</tr>
<tr>
<td>2012</td>
<td>Encourage Integrated Healthcare Systems</td>
</tr>
<tr>
<td></td>
<td>Decrease Health Disparities</td>
</tr>
<tr>
<td></td>
<td>Reduce Administrative Costs</td>
</tr>
<tr>
<td></td>
<td>Link Payment to Quality Care</td>
</tr>
<tr>
<td>2013</td>
<td>Increase Preventive Care Coverage</td>
</tr>
<tr>
<td></td>
<td>Increase Medicaid Payments to Primary MDs</td>
</tr>
<tr>
<td></td>
<td>Expanding Bundled Payments</td>
</tr>
<tr>
<td></td>
<td>Open Enrollment in Health Insurance Marketplace effective October 1</td>
</tr>
<tr>
<td>2014</td>
<td>Start of Health Insurance Coverage through the Marketplace</td>
</tr>
<tr>
<td></td>
<td>Promote Individual Responsibility</td>
</tr>
<tr>
<td></td>
<td>Increase Access to Medicaid</td>
</tr>
<tr>
<td></td>
<td>Eliminate Annual Limits of Insurance Coverage</td>
</tr>
<tr>
<td></td>
<td>Increase of Small Business Health Insurance Tax Credit</td>
</tr>
</tbody>
</table>

(continues)
be denied treatment for preexisting conditions, face annual and lifetime dollar limits and more. Americans with plans that lose grandfathered status will either have to switch to a new version of the plan or choose a different plan. In many cases Americans will be able to find a comparable plan on their State's health insurance marketplace and may even qualify for subsidies. The deadline for choosing a qualified plan is 2017.

**Title 1—Affordability and Accessibility of Healthcare**

The following are some of the major reforms that were implemented in 2010:

- Eliminate lifetime and unreasonable annual caps or limits on healthcare reimbursement with annual limitations prohibited by 2014.
- Provide assistance for the uninsured with preexisting conditions and prohibit denial of insurance coverage for preexisting conditions for children.
- Develop a temporary national high-risk pool for health insurance for individuals with preexisting conditions who have no insurance.
- Extend dependent coverage up to age 26.
- Establish www.healthcare.gov for consumers to access information about healthcare insurance.
- Create a reinsurance program for retirees who are not yet eligible for Medicare.

**Discussion**

In the past, health insurance companies would establish an annual or lifetime cap on reimbursement of consumers' healthcare insurance claims. This practice would be eliminated. Unlike the past, health insurance companies would also be prohibited from dropping individuals and children with certain conditions or not providing insurance to those individuals with preexisting conditions. This Pre-Existing Condition Insurance Plan (PCIP) provides new healthcare coverage options to individuals who have a preexisting condition and have had no insurance for the preceding six months. This served as a bridge to 2014, when all discrimination against preexisting conditions was prohibited.

Prior to the ACA, dependent coverage stopped at age 25. The act requires insurance companies to cover young adults on their parents’ insurance until age 26, even if they are not living with their parents, are not declared dependents on their parents’ taxes, or are...
By October 1, 2013, states were required to establish the Health Insurance Marketplaces, where consumers can obtain information and buy health insurance. Open enrollment for health insurance also began on October 1, 2013, for health insurance that became effective January 1, 2014. Most individuals who were uninsured must have enrolled by January 1, 2014, in an insurance plan that has minimum essential healthcare coverage or pay an annual fee.

In the past, there were issues with health insurance companies denying coverage based on health status or other conditions. Premiums now will be based on family type, geography, tobacco use, and age. In 2014–2016, only individuals and small-group employers were eligible to participate in the Marketplaces. In 2017, states can permit large group employers to participate. States may also organize regional exchanges. On May 8, 2013, the U.S. Department of Labor (DOL) issued guidance for employers regarding the requirement to notify employees of coverage options available through the exchanges (United Health Care, 2016). The ACA also established a summary of benefits and coverage (SBC), which offers consumers the opportunity to easily compare health insurance plans.

Consumer Operated and Oriented Plans (CO-OPs), which are member-run health organizations in all 50 states and must be consumer focused with profits targeted to lowering premiums and improving benefits, were established.

The Centers for Consumer Information and Insurance Oversight awarded nearly $70 million in cooperative agreements to 105 organizations to provide assistance to insurance marketplaces. Health insurance plans in the Marketplaces must offer at a minimum the following essential health benefits:

- Ambulatory patient services (outpatient care individuals receive without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after a baby is born)
- Mental health and substance-use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs

Also, a government temporary reinsurance program for employers who provide coverage to retirees over age 55 who are not yet eligible for Medicare will reimburse the employer 80% of the retiree claims of $50,000–$90,000. The act created a $5 billion program to provide financial assistance for employment-based plans to supply this coverage. This program was effective until January 2014, when the state-based Health Insurance Marketplaces were put in place and retirees not yet eligible for Medicare could buy their own insurance (U.S. General Accountability Office, 2016).

The following are selected major reforms that were implemented by 2014:

- Insurance companies were prohibited from setting insurance rates based on health status, medical condition, genetic information, or other related factors.
- Private health insurance coverage offered in the Marketplaces must offer the same essential health benefits (EHBs).
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  - Maternity and newborn care (care before and after a baby is born)
  - Mental health and substance-use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
  - Prescription drugs

In July 2010, the federal government established a web portal, www.healthcare.gov, to increase consumers’ awareness about their eligibility for specific healthcare insurance company information and about governmental programs. This website was designed to provide information to the 36 states that opted not to create their own state exchanges. The website is an opportunity for individuals to sign up for health insurance plans. The projected date for open enrollment on healthcare.gov was October 1, 2013, with the legal requirement to sign up for 2014 healthcare coverage by December 15, 2013. However, serious technological problems occurred, which was very frustrating to those attempting to sign up for plans. Estimates indicated that only one percent of potential enrollees were able to enroll in plans during the first weeks of the website operation. The federal government did not anticipate the high volume on the website. There were also problems with the website’s design. The federal government hired contactors to fix the website but problems continue to plague the website for several weeks during its initial launch. The poor implementation of the website was heavily criticized. U.S. Secretary of Health and Human Services Kathleen Sebelius was forced to resign in November 2014. Enrollment for 2015 was smoother. Open enrollment for 2016 began on November 1, 2015, and ended on January 31, 2016.

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The following are selected major reforms that were implemented by 2014:

- Insurance companies were prohibited from setting insurance rates based on health status, medical condition, genetic information, or other related factors.
- Private health insurance coverage offered in the Marketplaces must offer the same essential health benefits (EHBs).
There are different types of plans that can be purchased on the marketplaces. **TABLE 2-2** outlines the different types of plans.

<table>
<thead>
<tr>
<th>Plan category</th>
<th>The insurance company pays</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: [http://www.healthcare.gov](http://www.healthcare.gov)

Generally, the bronze levels have the lowest premiums but have the higher out of pocket expenses. The gold and platinum have the highest premiums but the lowest out of pocket expenses. When the healthcare consumer completes the marketplace application, information will be analyzed to determine if there are subsidies available based on income. A new 2016 feature allows the consumer to enter their prescription drugs and preferred providers to determine which plans will cover them (Understanding marketplace plans, 2016).

The Small Business Health Options (SHOP) was developed as part of the Marketplace to provide insurance plans from private insurance companies for businesses who have 100 or fewer employees. If the business has 25 or less employees, they may qualify for a health care tax credit for up to 50% of the premium costs.

The DHHS’s Centers for Consumer Information and Insurance Oversight is responsible for the oversight of the health insurance provisions of the ACA. They will work with state governments to ensure the Marketplaces are being implemented properly. They will also help states with reviews of any unreasonable rate increases by insurance companies and other social regulations (CMS, 2016b). The Health Resources and Services Administration also awarded $150 million to 1200 community health centers to enroll uninsured individuals.

A controversial initiative is the Cadillac tax, effective 2018, that taxes generous health insurance plans that were typically negotiated by unions. This would force employers to offer less generous packages, which would limit health care spending over time. This has been a controversial mandate. Some economists who support the tax, indicate employees would be compensated by higher wages. The Cadillac tax would generate $91 billion in revenues over 10 years. The arguments.
against the Cadillac tax indicate that it would impact lower income employees because employers would raise the employees cost sharing to offset the tax. This mandate could be repealed in the next administration (Altman, 2016).

Effective 2017, employers who have 100 or more full-time equivalent employees must offer them health insurance.

**Enrollment Data for Marketplaces**

The current enrollment numbers (as on February 2016) are roughly 12.7 million in the marketplace, and very roughly 20 million between the Marketplace, Medicaid expansion, young adults staying on their parents plan, and other coverage provisions. The uninsured rate remains at an all-time low with 9.1% of under 65 uninsured as of the end of 2015 according to CDC Gov data. Generally, 2016 saw a rough increase of all the 2015 numbers (Obamacare enrollment, 2016).

A public plan option was also authorized to create a government-run health insurance agency that would compete with other health insurance companies. This would provide health insurance for individuals who could not afford private health insurance premiums. This program has not been implemented. However, in 2013, this type of program was reintroduced by the Senate as an amendment to the ACA. The purpose of these programs is to increase the number of consumers who have access to affordable health care.

### Title II–The Role of Public Programs: Medicaid, CHIP, Medicare

- Medicaid eligibility has been expanded to cover lower incomes. The baseline is all individuals whose incomes are under 133% of the federal poverty level. States will receive matching funds to expand their Medicaid services, increasing accessibility to more consumers. As of 2016, 32 states had opted to expand their Medicaid programs. More states are expected to adopt the expansion because the federal government is willing to pay 100% of the state's costs through 2016 for the expansion.
- The Children's Health Insurance Program (CHIP) will be required to maintain income level eligibility through 2019.
- A new Medicaid benefit, Community First Choice, has been created to offer community services.
- In 2010, a onetime $250 rebate was given to Medicare Part D beneficiaries who entered the coverage gap, also known as the “donut hole,” in 2010. There are approximately 4 million seniors impacted by this financing gap.

**Medicare beneficiaries will receive an annual wellness visit with no cost sharing.**

### Discussion

Medicaid will expand to increase coverage for consumers who are not Medicare eligible. As discussed earlier, this mandate was contentious because states felt that the federal government was forcing them to expand their programs by withholding federal aid if states refused to expand. The federal government has limited the withholding mandate to certain newly eligible populations. It also simplifies enrollment for both individuals and families. The federal government will increase its payments to the states through 2019. Individuals will be able to enroll in these programs through the exchange and state websites. Community First Choice is an optional Medicaid benefit that focuses on community health services to Medicaid enrollees with disabilities. This will enable consumers to receive care at home or at community health centers rather than going to a hospital or another healthcare facility. This option became available on October 1, 2011, and provided a six percent increase in federal matching payments to states for expenditures related to this option. As of March 2016, eight states are utilizing this option (Medicaid.gov, 2016). These mandates will enable lower-income consumers and children to have access to health care at an affordable cost.

There was an issue with the Medicare Part D coverage gap, more commonly known as the donut hole for Medicare Part D. The coverage gap or donut hole starts after the beneficiary and the drug plan together have spent a designated amount for the covered drugs. The donut hole changes every year. For example, in 2016, once the beneficiary enters the coverage gap ($3,310), the individual must pay 45% of the plan’s cost for covered brand drugs and 58% of the plan’s cost for covered generic drugs until he or she reaches the end of the coverage gap ($4,850 in 2016); then a copayment for each covered drug is paid until the end of the year. Not all beneficiaries will reach the coverage gap because their drug costs are not that high. This increase in beneficiary out-of-pocket payments was very expensive for those enrolled and often resulted in individuals not obtaining necessary medication because of cost. Since the passage of the ACA, 6.6 million Medicare enrollees who were impacted by the donut hole have saved over $7 billion on prescription
drugs, which averages $1,061 per beneficiary. In addition to the $250 rebate check, those impacted received discounts and increased coverage. They will continue to receive these benefits until the coverage gap is closed in 2020 (CMS, 2016a).

**Title III–Improving the Quality and Efficiency of Health Care**

- The Independent Payment Advisory Board was established to develop quality improvement proposals.
- The Patient-Centered Outcomes Research Institute was established.
- Ann Independence at Home program was created.

**Discussion**

Medicare payments will be linked to the quality of care. Long-term care hospitals, rehabilitation services, cancer hospitals, and hospice providers will participate in quality performance measures. A federal inter-agency Working Group on Healthcare Quality was established to develop national initiatives on quality performance. They collaborate with other federal agencies to implement the National Quality Strategy developed by the DHHS (AHRQ, 2016). Also, a new Center for Medicare and Medicaid Innovation will research different payment and delivery systems. Effective in 2012, hospital reimbursements were based on the hospital’s percentage of preventable readmissions of Medicare beneficiary patients. The Center for Medicare and Medicaid Innovation’s goal is to support the development and testing of innovative healthcare payment and service delivery models. The center currently has several demonstration projects for payment and care models, including accountable care organizations, value-based purchasing, and coordinated and prevention care.

The 15-member Independent Payment Advisory Board will present to Congress proposals for cost savings and quality performance measures. This 15-member board, appointed by the President and confirmed by the Senate, will make recommendations to reduce Medicare spending, which will be implemented by the DHHS. This is the first time Congress has established a mechanism to set a cap on future Medicare spending (Moffitt, 2011).

The community health teams will increase access to community-based coordinated health care. Local healthcare providers will be encouraged to develop medication management services to assist with chronic disease management. These measures increase the efficiency and effectiveness of Medicare. Also, there is a continued focus on community health activities that reduce the cost of healthcare services.

The Patient-Centered Outcomes Research Institute (PCORI) compares the outcomes of disease treatments. A nonprofit private organization established in 2010, the PCORI is responsible for providing assistance to physicians, patients, and policy makers in improving health outcomes and perform research that targets quality and efficiency of care. A trust fund has been established to pay for the PCORI’s administration and research. According to its website, the PCORI facilitates more efficient research, which could significantly increase the amount of information available to healthcare decision makers and the speed at which it is generated. The PCORI has invested more than $250 million in the development of PCORnet: The National Patient-Centered Clinical Research Network. This network has partnerships in all 50 states. PCORnet established a functional research network of health information that is nationally representative and will significantly reduce the time and effort required to start studies and build the necessary infrastructure to conduct them. It will support a range of study designs, including large, simple clinical trials and studies that combine an experimental component, such as a randomized trial, with a complementary observational component. Because PCORnet enables studies to be conducted using real-time data drawn from the everyday healthcare experiences of people across the United States, it should increase the relevance of questions that can be studied and the usefulness of the study results. Research is focusing on prevalent health issues such as diabetes, obesity, breast cancer, hypertension, and heart disease (PCRI, 2016).

The Independence at Home program provides Medicare beneficiaries with at-home primary care and allocate any cost savings of this type of care to healthcare professionals who reduce hospital admissions and improve health outcomes (American Association of Nurse Practitioners, 2016). This three-year demonstration program, started in January 2012, assessed home health care for Medicare beneficiaries who are chronically ill. Medical care is administered by a team of providers and is available seven days per week around the clock. The goal of the program is to compare the cost of this type of care to hospital care of those Medicare beneficiaries who are chronically ill (Home Caregiver Services, 2016). According to the CMS, Independence at Home participants saved over $25 million in the demonstration’s first performance year—an
average of $3,070 per participating beneficiary—while delivering high-quality patient care in the home. The CMS awarded incentive payments of $11.7 million to nine participating practices that succeeded in reducing Medicare expenditures and met designated quality goals for the first year of the demonstration (CMS, 2016f).

**Title IV–Prevention of Chronic Disease and Improving Public Health**

- The National Prevention, Health Promotion, and Public Health Council (National Prevention Council) was established to develop a national health prevention strategy.
- To waive copayments or cost sharing for most preventive services, Medicare will cover 100% of the total cost.
- Medicaid must provide coverage to pregnant women for counseling and drug therapy for tobacco cessation and provide incentives for all enrollees who participate in healthy lifestyles.

**Discussion**
The National Prevention Council is an interagency council of 17 federal organizations chaired by the U.S. Surgeon General to promote health policies and assess infrastructures. The health priorities include tobacco-free living, drug and alcohol prevention programs, injury and violence-free living, active lifestyles for all ages, mental and sexual health, and healthy eating. The council's 2014 annual report included the following statistics:

1. Between 2012 and 2013, the number of tobacco-free college campuses increased by almost 70% from 774 to 1343;
2. By the end of 2013, over 6,500 U.S. schools had received a certification for promoting nutrition and physical activity;
3. The number of hospitals that promoted breastfeeding to new mothers tripled between 2008 and 2013;
4. Between 2012 and 2013, the national homeless rate dropped 7%, with an 8% drop in Veterans' homelessness; and
5. By 2012, 76% of U.S. school districts offered mental health or social services to students.

The Prevention and Public Health Fund was established to provide funding for public health programs. As of 2014, approximately $927 million was available to fund activities in 2015. A large portion of the funding was allocated to the Centers for Disease Control and Prevention. Research indicates that these types of funding programs have the potential to improve health outcomes and reduce healthcare costs (American Public Health Association, 2016).

In addition, there will be no copayment for Medicare annual wellness visits and the development of a patient prevention program (discussed in Title II). Medicaid will also expand its coverage for prevention activities such as drug or tobacco cessation programs. There will be additional federal funding to Medicaid programs if they provide free immunizations or other clinical preventive services.

**Title V–Healthcare Workforce**

- The ACA established a National Health Care Workforce Commission to review healthcare workforce and projected needs. Funding was never appropriated for this initiative.
- The ACA developed programs to increase the supply of healthcare workers by training and education incentives.
- The ACA developed a Primary Care Extension Program (PCEP) to educate and provide assistance to primary care providers about preventive medicine. Funding was never provided for this program.

**Discussion**
The National Health Care Workforce Commission was developed to review workforce needs and make recommendations to the federal government to ensure that national policies are in alignment with consumer needs. As of January 2013, Congress had allocated $3 million for the commission, but funds were never appropriated and therefore the Commission has never met.

The PCEP was established to provide technical assistance to primary care providers about health promotion, chronic disease management, mental health, and preventive medicine. These initiatives are focused on prevention and health promotion. Family medicine groups have recommended annual funding of $120 million to administer the program. The PCEP would establish patient-centered medical homes by creating community-based health extension agents, whose role was to collaborate with local health agencies to identify community health priorities and determine the workforce needs for local areas. Because funding was not awarded, the AHRQ used existing appropriations to develop a pilot program in 2011. It was renamed IMPaCT, which stands for Infrastructure for Maintaining Primary Care Transformation. They provided...
funding for four projects from 2011 through 2013 in Oklahoma, North Carolina, Pennsylvania, and New Mexico. The states created a primary care team that would coordinate efforts between primary care and public health efforts. The grantees felt it was a success with reporting of healthier patient outcomes.

**Title VI–Transparency and Program Integrity**

- The DHHS will publish standardized information on long-term care options for consumers so they can compare facilities.
- A national system for direct patient access to employee background checks will be established.
- A process to screen Medicare and Medicaid providers will be created.
- The Elder Justice Act, intended to prevent and eliminate elder patient abuse, was enacted.

**Discussion**

As the U.S. population is graying, the number of individuals who live in assisted living and skilled nursing facilities at the end of their lives is increasing. There will be continued enrollment in both Medicare and Medicaid. These mandates focus on the importance of providing information about long-term facilities to consumers so they can select the appropriate facility for their relative. This title also focuses on providing additional information about the quality of the care given at long-term facilities. There is also a screening mechanism to ensure that these service providers are providing quality care.

The Elder Justice bill was introduced in the Senate in 2003 and contained landmark initiatives in the development of a national policy to prevent elder abuse and neglect, which continues to be a social issue. The Elder Justice Act was finally passed as part of the ACA. It targets abuse, neglect, and exploitation of the elderly. However, Congress did not award funding until 2012 for the activities associated with the act. In 2012, the DHHS transferred nearly $6 million in funding to implement Elder Justice Act activities in tribal organizations and programs in Texas, New York, Alaska, and California. Projects included forensic accountants to target elder financial abuse and screening tools to detect elder abuse. In 2013, $2 million was transferred to develop a reporting system for elder abuse. No funding was awarded in 2014. However, in 2015, the Elder Justice Act received $4 million in direct funding for the first time (Elder Justice Act, 2014).

**Title VII–Improving Access to Innovative Medical Therapies**

- The existing section 340B of the Public Health Service Act of 1992 will be expanded so there will be more affordable drugs for children and underserved community residents.

**Discussion**

The 340B section expansion will allow more drug discounts for inpatient use at children's hospitals, cancer hospitals, critical care hospitals, and rural centers. This mandate increases drug affordability for patients who may need long-term care. Drug companies that participate in the Medicaid drug rebate program must sign pricing agreements for discounts on outpatient drugs purchased by qualified public health facilities (Mulcahey, Armstrong, Lewis, & Mattke, 2014).

**Title VIII–Community Living Assistance Services and Supports**

- The CLASS Independence Benefit Plan, a self-funded long-term care insurance program for individuals with limited financial assistance, will be established.

**Discussion**

The CLASS Plan, effective January 1, 2011, enables consumers to purchase community living assistance. Although supported by many community organizations, the Obama administration indicated it was not a viable program and the act was repealed on January 1, 2013 (The Arc, 2012).

**Title IX–Revenue Provisions**

- Employers must report on the employee's annual W-2 form the value of the health insurance benefit coverage provided by the employer. An excise tax will be levied on expensive employer health insurance plans.
- An annual flat fee is imposed on branded-prescription pharmaceutical companies and exporters, the medical device manufacturing industry, and health insurance providers, according to market share. Also, there is an excise tax on indoor tanning services.
- Various provisions of the ACA affect cafeteria plans for healthcare benefits to employees, which enable them to select different benefits based on current lifestyle.
Discussion

The requirement for employers to inform their employees about the cost of the health insurance benefit as well as report the cost on W-2 forms emphasizes transparency. The employer must report it accurately because it will be reported on a federal form. In addition, a 40% excise tax will be placed on expensive employer-sponsored health plans.

Annual pharmaceutical fees or the branded prescription drug fees of approximately $2.5 billion will be applied to the drug manufacturing sector and are based on the market share of the U.S. drug market for branded prescription drugs. This is allocated across the industry sector with some exclusions. The fees began in 2011. The fee component, for example, was $2.5 billion in 2011 and $2.8 billion in 2012. The fee will steadily rise to $4.1 billion in 2018 and will be $2.8 billion a year thereafter. These fees will cost the industry approximately $85 billion over a decade (Office of the Inspector General, 2014). The same type of fee, initially $8 billion, was first applied to the health insurance industry in 2014. The fee will increase in years thereafter. It is important to note that these fees are nondeductible. A tax will be imposed on medical devices equal to 2.3% of the sales price and it is deductible. The fees and taxes will contribute to the operation of the healthcare reform mandates. Effective July 1, 2010, a 10% excise tax was imposed on indoor-tanning services.

A cafeteria plan is a type of employer-sponsored benefit plan that allows employees to select the type of benefits appropriate for their lifestyle. This plan could benefit both employers and employees because not all employees need the same type of benefits. Although cafeteria plans can be difficult to administer, they can be more cost effective because employees have different healthcare needs and may require less healthcare insurance coverage in some instances.

Title X—Strengthening Quality Affordable Care

- A Physician Compare website was developed.
- A Nursing Home Compare website was developed.
- The Cures Acceleration Network was developed.
- Permanent legal authority was provided for the Indian Health Care Improvement Act (IHCIA), which provides health care to American Indians and Alaska Natives.

Discussion

The Physician Compare tool, part of the CMS website, has been established to help consumers with research about physicians who accept Medicare. It provides basic information about their address and contact information, education, languages spoken, gender, hospital affiliation, Medicare acceptance, and specialty (Medicare.gov, 2016a). A Nursing Home Compare tool, also located on the CMS website, was developed to enable consumers to research all nursing homes in the United States that are Medicare and Medicaid certified. A consumer can review facilities’ inspection findings from the past three years. There are also Hospital, Home Health, and Dialysis Compare software tools (Medicare.gov, 2016b).

Also, the National Institutes of Health (NIH) is establishing the Cures Acceleration Network, a grants center to encourage research in the cure and treatment of diseases. All of these initiatives are targeting primary prevention, increasing consumer awareness of their health care, and providing incentives for disease research. The NIH may award grants annually up to $15 million to research these priority areas.

The Indian Healthcare Improvement Act, originally passed in 1979 but which had not been funded starting in 2000, was made permanent by the ACA. The improved act will authorize the establishment of comprehensive health services for American Indians and Alaskan Natives. The major goal of the act is to improve access and quality of care, including mental health services and alcohol and substance abuse programs to these targeted populations (U.S. Department of Health and Human Services, 2016).

Conclusion

The Patient Protection and Affordable Care Act of 2010, or Affordable Care Act, and its amendment have focused on primary care as the foundation for the U.S. healthcare system (Goodson, 2010). The legislation has focused on 10 areas to improve the U.S. healthcare system, including quality, affordable, and efficient healthcare; public health and primary prevention of disease; healthcare workforce increases; community health; and increasing revenue provisions to pay for the reform. However, once the bill was signed, several states filed lawsuits. Several of these lawsuits argued that the act violates the U.S. Constitution because of the mandate of individual healthcare insurance coverage as well as that it infringes on states’ rights with the expansion of Medicaid (Arts, 2010). The 2012 U.S. Supreme Court decision that
upheld the constitutionality of the individual mandates should decrease the number of lawsuits. Despite these lawsuits, this legislation has clearly provided opportunities to increase consumer empowerment of the healthcare system by establishing the state American Health Benefit Exchanges, providing insurance to those individuals with preexisting conditions, eliminating lifetime and annual caps on health insurance payouts, improving the healthcare workforce, and providing databases so consumers can check the quality of their health care. The 10 titles of this comprehensive legislation are also focused on increasing the role of public health and primary care in the U.S. healthcare system and increasing accessibility to the system by providing affordable health care.

Although this legislation continues to be controversial, a system-wide effort needed to be implemented to curb rising healthcare costs, although there have been reports that healthcare costs are increasing and consumers are paying higher cost sharing amounts. There are five areas of health care that account for a large percentage of healthcare costs: hospital care, physician and clinician services, prescription drugs, nursing, and home healthcare expenditures (Longest & Darr, 2008). The legislation targets these areas by increasing quality assurance and providing a system of reimbursement tied to quality performance, providing accessibility to consumers regarding the quality of their health care, and increasing access to community health services. Also, the Affordable Care Act has focused on improving the U.S. public health system by increasing the accessibility to primary prevention services such as screenings and wellness visits at no cost. The ACA has mandated that healthcare providers make available certain services with no cost sharing to the healthcare consumer: 15 preventive services for adults, 22 preventive services for women, 25 preventive services for children, and 23 preventive services for Medicare enrollees (Youdelman, 2013). Revenue provisions are in place to offset some of the costs of this legislation. With continued controversy, it will be difficult to quickly assess the cost effectiveness and impact of this health reform on improving the health care of U.S. citizens. The President had to veto a repeal of the bill, and the U.S. House of Representatives created a task force to craft an improved ACA. In light of the upcoming November 2016 presidential election, it is difficult to assess at this point whether the ACA will remain in place. Regardless of political views, many individuals now have access to health care because of the ACA. The next major issue is whether typical middle-class Americans can afford the high deductibles and increased cost sharing for their healthcare.
Impact of the Affordable Care Act on Healthcare Services

References


The Clinical Advisor. (2013). Family medicine group recommends funding Primary Care Extension Program.


Student Activity 2-1

In Your Own Words
Based on this chapter, please provide an explanation of the following concepts in your own words. DO NOT RECITE the text.

**Cadillac tax:**
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**Cafeteria plan:**
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**Community First Choice:**
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**Consumer Operated and Oriented Plan:**
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**Elder Justice Act:**
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**IMPaCT:**
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**Independent Payment Advisory Board:**
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Student Activity 2-2

Complete the following case scenarios based on the information provided in the chapter. Your answer must be IN YOUR OWN WORDS.

Real-Life Applications: Case Scenario One

Your mother has a chronic healthcare condition that requires many visits to her healthcare provider. She recently changed jobs, which will require your family to move to a new state. She is also afraid that she will not receive healthcare insurance from her new company and is worried about finding a new provider to take care of her.

Activity

Explain to her about the new healthcare reform bill and how that will impact her situation.

Responses
Case Scenario Two

You have two elderly relatives who you think are not being treated well by their nursing home. You are not sure what to do. You speak to your parents about it and they suggest you research this issue. They know there are some mandates in the ACA regarding elderly care.

Activity
Perform research regarding the Elder Justice Act to determine if there are any solutions to this problem.

Responses
Case Scenario Three
Your mother is turning 55 and is being downsized from her job. She has yet to find another job. She has COBRA benefits for a certain period of time but is not sure what to do after. She is too young for Medicare.

Activity
Visit the www.healthcare.gov website to determine if there are any options for her to purchase health insurance.

Responses
Case Scenario Four
You work for a healthcare facility that would like to apply for a grant to develop new ways to improve the quality of its health care.

Activity
Visit the Innovation Center on the www.cms.gov website. Develop a report on possible grants available for your healthcare facility.

Responses
Student Activity 2-3

Internet Exercises

Write your answers in the space provided.

- Visit each of the websites listed here.
- Name the organization.
- Locate the organization's mission statement on its website.
- Provide a brief overview of the activities of the organization.
- How do these organizations participate in the U.S. healthcare system?

Websites

http://www.healthcare.gov

Organization Name:

Mission Statement:
Overview of Activities:

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Importance of Organization to U.S. Health Care:

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http://www.allhealth.org

Organization Name:

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Mission Statement:

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Overview of Activities:

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Importance of Organization to U.S. Health Care:

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http://www.pnhp.org

Organization Name:

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Mission Statement:

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Overview of Activities:

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Importance of Organization to U.S. Health Care:

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http://www.ahip.org

Organization Name:

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Mission Statement:

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Overview of Activities:

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Importance of Organization to U.S. Health Care:

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http://www.hfma.org

Organization Name:

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Mission Statement:

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Overview of Activities:

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Importance of Organization to U.S. Health Care:

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http://www.acep.org

Organization Name:

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Mission Statement:

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Overview of Activities:

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Student Activity 2-4

Discussion Questions

The following are suggested discussion questions for this chapter.

1. Select three initiatives of the Affordable Care Act in any of the 10 title areas that you think are important to improving our healthcare system. Defend your answer.

2. Do you think that the mandate for individual health insurance coverage is constitutional? Defend your answer.

3. What do you think of the Nursing Home Compare website? Do you think the provides valuable information for consumers to support these important healthcare decisions?
4. Discuss the new Patient Bill of Rights developed by the Affordable Care Act, and why.

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5. What is a cafeteria plan? Do you think this is an effective way to provide health insurance benefits to employees? Perform an Internet search and locate a company that provides a cafeteria plan and report back to the discussion board on what the company offers.

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▶ Student Activity 2-5

Current Events
Perform an Internet search and find a current events topic from the past three years that is related to this chapter. Provide a summary of the article and the link to the article and why the article relates to the chapter.

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Chapter 2 Impact of the Affordable Care Act on Healthcare Services