

Chapter 2

Impact of the Affordable Care Act on Healthcare Services

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.
- Define community choice and its impact on healthcare services.
- The ACA bans health plans from establishing lifetime dollar limits on 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.

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.

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**, was 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, in part, focused 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 government 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 the healthcare system expenditures comprising 17.6% of the U.S. gross domestic product and with millions of Americans not having the accessibility of health care, resulting in poor health indicators, the current administration's priority was to create mandated healthcare reform. The Congressional Budget Office estimates that the act will enable an additional 32 million Americans or a total of 94% of Americans to have access to health insurance (ProCon.org, 2013b).

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 inaction. As a result of this mandate, there were over 20 states that 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. 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, 2013a). 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 is required to develop state incentives to accept the Medicaid expansion and to restrict the type of funding limitations to states who refuse the Medicaid expansions (Svendiman & Baumrucker, 2012).

MAJOR PROVISIONS OF THE AFFORDABLE CARE ACT

Table 2-1 provides a summary of the 46 major action items of the ACA (Centers for Medicare & Medicaid Services, 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.

Title 1—Affordability and Accessibility of Healthcare

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

- Create small business tax credits for employers who provide health insurance.
- Eliminate lifetime and unreasonable annual caps or limits on healthcare reimbursement with annual limitations prohibited by 2014.
- Provide assistance for the uninsured with pre-existing conditions and prohibit denial of insurance coverage for pre-existing conditions for children.
- Develop a temporary national high-risk pool for health insurance for individuals with pre-existing 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.

TABLE 2-1

Timeline for Affordable Care Act Regulations

2010	Affordable Care Act Signed into Law
	Small Business Health Insurance Tax Credits (deferred until 2015)
	States to Increase Medicaid coverage
	One-Time \$250 rebate for Medicare Part D Donut Hole
	Target Healthcare Fraud
	Early Retiree Reinsurance Program (ERRP)
	Insurance for Pre-Existing Conditions
	Online Information for Healthcare Consumers at http://www.healthcare.gov
	Extend Age for Young Adults Coverage to 26
	Free Preventive Care
	Prohibit Insurance from Dropping Coverage
	Appeal of Insurance Coverage Denials
	Eliminate Lifetime Limits on Insurance Coverage
	Regulate Annual Limits on Insurance Coverage
	Ban of Coverage Denial of Children with Pre existing Conditions
	Accountability of Insurance for High Rate Hikes
	Focus on Primary Health Workforce
	Establish State Consumer Assistance Programs
	Prevent Disease and Illness Initiatives
	Strengthen Community Health Centers
Increased Payments for Rural Health	
2011	Prescription Drug Discounts
	Free Preventive Care for Seniors
	Reduce Healthcare Premiums
	Strengthen Medicare Advantage
	Improve Quality and Efficiency of Health Care
	Improve Senior Care Post Discharge from Hospital
2012	Innovation to Reduce Costs
	Increase Home and Community Health Services
	Encourage Integrated Healthcare Systems

(continues)

TABLE 2-1

Timeline for Affordable Care Act Regulations (continued)

2012	Decrease Health Disparities
	Reduce Administrative Costs
	Link Payment to Quality Care
2013	Increase Preventive Care Coverage
	Increase Medicaid Payments to Primary MDs
	Expanding Bundled Payments
2014	Open Enrollment in Health Insurance Marketplace
	Establish Health Insurance Marketplace
	Promote Individual Responsibility
	Increase Access to Medicaid
	Make Care More Affordable
	Coverage for Participants in Clinical Trials
	Eliminate Annual Limits of Insurance Coverage
2015	Anti-Discrimination of Pre-Existing Conditions or Gender
	Increase of Small Business Health Insurance Tax Credit
	Payment to Physicians Based on Quality Care

Source: Data from Centers for Medicare & Medicaid Services. Timeline of the health care law. Retrieved from <https://www.healthcare.gov/timeline-of-the-health-care-law/#part=1>

Discussion

The ACA establishes tax credits for small businesses to assist them with providing employee insurance benefits. This is a multi-phase program. The first phase provides a credit up to 35% of the employer's contribution to the employee's health insurance. Although there are up to 4 million small businesses eligible for these credits, according to a U.S. General Accountability Office (GAO) 2012 report, less than 200,000 small businesses have claimed the tax credit because it was not large enough to incentivize small businesses to offer health insurance. There are also complicated administrative procedures that limited claims. The government is reviewing the procedures to streamline the application process. *Due to business input, this mandate has been deferred to 2015.* (U.S. General Accountability Office, 2012).

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 pre-existing conditions. This Pre-Existing Condition Insurance Plan (PCIP) provides new healthcare coverage options to individuals who have a pre-existing condition and have had no insurance for the last 6 months. This serves as a bridge to 2014, when all discrimination against pre-existing conditions will be 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 no longer students. However, this would not apply to individuals who have employer-based coverage (U.S. Department of Labor, 2010).

In July 2010, the federal government established a Web portal, www.healthcare.gov, to increase consumer awareness about their eligibility for specific healthcare insurance company information and about government programs. The Web portal will be developed in phases. 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 needed financial assistance for employment-based plans to supply this coverage. This program will be effective through January 2014, when the state-based Health Insurance Marketplaces will be in place and retirees not yet eligible for Medicare can buy their own insurance (U.S. General Accountability Office, 2012).

The following are selected major reforms that must be implemented by 2014:

- Insurance companies will be 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)**.
- By October 1, 2013, states must establish the **Health Insurance Marketplaces**, which are marketplaces where consumers can obtain information and buy health insurance. Open enrollment for health insurance also begins on October 1 for health insurance that will become effective January 1, 2014. Most individuals who are uninsured must enroll in an insurance plan by January 1, 2014 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 are eligible to participate in the Marketplaces. In 2017, states may permit large group employers to participate. States may also organize regional exchanges. On May 8, 2013, the Department of Labor (DOL) issued guidance for employers regarding the requirement to notify employees of coverage options available through the exchanges. (United Health Care, 2013). The ACA also established a **Summary of Benefits and Coverage (SBC)** which offers consumers

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the opportunity to easily compare health insurance plans.

- There will also be **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.
- There is enrollment assistance for the Health Insurance Marketplaces. The **Centers for Consumer Information and Insurance Oversight** awarded nearly \$70 million in cooperative agreements to 105 organizations to provide assistance to insurance marketplaces.
- The **Small Business Health Options Program (SHOP)** is available to small businesses with up to 100 employees to purchase health coverage. These programs are required to maintain a call center for customer service. Employers who have 50 or more employees must automatically enroll new full-time employees in healthcare coverage. Employers would pay a fee of \$3,000 if they did not offer affordable insurance. Employers will also receive tax credits depending on the size of the company. *Based on input from business groups, this mandate has been delayed until 2015.*

Health insurance plans in the Marketplaces must offer at a minimum the following essential health benefits:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services (Centers for Medicare & Medicaid Services, 2013d)

Health Insurance Marketplaces, run by state or federal government, are central locations for healthcare consumers to purchase health insurance coverage. They provide standardized information on the different types of health insurance coverage to suit consumer needs. Consumers complete an application to determine what types of coverage are available to them, based on their need. Health insurance coverage is provided by private health insurance companies. Open enrollment for 2014 started on October 1, 2013.

If individuals do not apply for health insurance coverage by March 31, 2014, which is when open enrollment ends, they will be required to pay a fee and cannot obtain coverage until the next annual open enrollment. However, if there is a **life qualifying event** such as job change or geographic change, they could be eligible to enroll. The 2014 fee is 1% of the individual's yearly income or \$95 per person, whichever is higher. The fee for an uninsured child is \$47.50. The maximum amount a family would pay is \$285. The fee does increase every year. In 2016, it is 2.5% of income or \$695, whichever is higher. Individuals who have very low income, participate in a religious sect that does not believe in health insurance, or are part of a federally recognized Indian tribe, will not be charged a fee (Centers for Medicare & Medicaid Services, 2013e).

The SBC was developed as a result of the ACA. This summary allows the consumer to compare the different types of benefits offered by health insurance companies. A consumer can compare price, benefits, and other features. This is required for all health insurance companies.

Recognizing that in some states only a small number of insurance companies offer coverage for individuals and small businesses, the Centers for Medicare and Medicaid Services has awarded nearly \$2 billion in loans to help create 24 new CO-OPs in 24 states. The CO-OP sponsors—consumer-run groups, membership associations, and other nonprofit organizations—are now moving forward to offer health coverage in competition with established commercial and nonprofit insurance companies. As of June 2013, the CO-OPs were hiring staff and obtaining licensure. The success of these CO-OPs may be dependent on the state Marketplaces. (Health Affairs, 2013; Office of Inspector General, 2013).

The Health and Human Services Administration'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 (Centers for Medicare & Medicaid Services, 2013b). The Health Resources and Services Administration also awarded \$150 million to 1,200 community health centers to enroll uninsured individuals.

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 those who could not afford private health insurance premiums. *This program has not been implemented.* However, in 2013, this type of program has been 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 under 133% of the federal poverty level. States will receive matching funds to expand their Medicaid services, increasing accessibility to more consumers. As of September 2013, 24 states have 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.
- 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 enter the coverage gap or **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. From 2014 to 2016, the federal government will assist the states with payment of the newly eligible individuals. The CHIP program will maintain its existing coverage for children through 2015. 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 their facility. This option became available on October 1, 2011 and provides a 6% increase in federal matching payments to states for expenditures related to this option (Medicaid.gov, 2013). These mandates will enable lower income consumers and children to have access to healthcare at an affordable cost.

There is an issue with the Medicare Part D coverage gap, more commonly known as the “donut hole” for Medicare Part D beneficiaries that this act should remedy. A typical beneficiary for Part D pays 25% of drug costs, including the deductible during the first part of the drug coverage phase. Once you reach the threshold of \$2,830, the donut hole is activated, which means the beneficiary pays 100% of the drug costs until both the plan and beneficiary costs reach the maximum of \$6,440. This maximum changes annually. Once this threshold is reached, which is called the catastrophic threshold limit, Medicare Part D will cover the costs of the drugs (approximately 95%), with the beneficiary paying \$2.40 for generic drugs and \$6.00 for brand drugs for the remainder of the year (Allsup, 2010). However, this donut hole restarts every year. This increase in beneficiary payout was very expensive for those enrolled and often resulted in individuals not obtaining necessary medication because of cost. In 2010, those beneficiaries that fall into the donut hole received a \$250 rebate check from Medicare (Bihari, 2010). 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

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coverage. They will continue to receive these benefits until the coverage gap is closed in 2020 (Centers for Medicare & Medicaid Services, 2013a).

Title III—Improving the Quality and Efficiency of Health Care

- The **Independent Payment Advisory Board** was established to develop quality improvement proposals
- Establishment of a **Patient-Centered Outcomes Research Institute**
- Creation of an **Independence at Home program**

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 interagency **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 U.S. Department of Health and Human Services. They convened in March and October 2011 to discuss the collaboration of federal agencies in the implementation of the national healthcare strategy (Agency for Healthcare Research and Quality, 2012). Also, a new **Center for Medicare and Medicaid Innovation** will research different payment and delivery systems. Effective 2012, hospital reimbursements will be based on the hospital's percentage of preventable Medicare readmissions of 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. They currently have 41 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 have the authority in 2014 to make recommendations to reduce Medicare spending, which will be implemented by the U.S. Department of Health and Human Services. 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) will compare 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. They will perform research that targets quality and efficiency of care. A trust fund has been established to pay for the administration and research of the PCORI (Sullivan, 2012).

The Independence at Home program will provide Medicare beneficiaries with at-home primary care and allocate any cost savings of this type of care to the healthcare professionals if they reduce hospital admissions and improve health outcomes (American Association of Nurse Practitioners, 2010). This 3-year demonstration program, starting in January 2012, assesses home health care for Medicare beneficiaries who are chronically ill. Medical care is administered by a team of providers and is available 7 days a 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, 2012).

Title IV—Prevention of Chronic Disease and Improving Public Health

- The **National Prevention, Health Promotion, and Public Health Council** (National Prevention Council) is 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.
- Require Medicaid coverage for counseling and drug therapy for pregnant women for tobacco cessation and incentives for enrollees who participate in healthy lifestyles.

Discussion

The National Health Prevention, Health Promotion, and Public Health Council, commonly called the National

Prevention Policy, published a report in 2011 that focused on six health priorities to improve the health of the United States. 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 lifestyle for all ages, mental and sexual health, and healthy eating. **The Prevention and Public Health Fund** was established to provide funding for public health programs. As of 2013, there is approximately \$616 million to fund activities. Research indicates that these types of funding programs have the potential to improve health outcomes and reduce healthcare costs (American Public Health Association, 2013).

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

- Establish a **National Health Care Workforce Commission** to review healthcare workforce and projected needs.
- Develop programs to increase the supply of healthcare workers by training and education incentives.
- Develop a **Primary Care Extension Program (PCEP)** to educate and provide assistance to primary care providers about preventive medicine.

Discussion

A **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 funding for the commission, which is approximately \$3 million.

As part of educational incentives to increase the workforce supply, the Nursing Student Loan Program will be expanded. Special loan programs will be implemented to providers who will be working in underserved areas. Workforce training will be provided to rural physicians, dentists, nurse practitioners in community health centers, and long-term care workers.

The Primary Care Extension Program (PCEP) will be 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 the emphasis of prevention and health promotion. However, as of 2013, there has been no funding allocated to this program. 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. Their role would be to collaborate with local health agencies to identify community health priorities and determine the workforce needs for local areas (The Clinical Advisor, 2013).

Title VI—Transparency and Program Integrity

- The Department of Health and Human Services will publish standardized information on long-term care options for consumers so they can compare facilities.
- Establish a national system for direct patient access to employee background checks.
- Creation of a screening process for Medicare and Medicaid providers.
- **Elder Justice Act** was established to prevent and eliminate elder patient abuse.

Discussion

As the U.S. population is graying, many individuals may spend part of their lives in nursing homes. 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 the providers of these services 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. The Elder Justice Act was finally passed as part of the ACA. It targets abuse, neglect, and exploitation of the elderly. There will also be incentives for employees who want to work at such facilities (Biancato, 2010). Funding was allocated to provide grants to study elder

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abuse. However, Congress did not award funding until 2012 for the activities associated with the act. In 2012, nearly \$6 million in funding was awarded to implement Elder Justice Act activities in tribal organizations and programs in Texas, New York, Alaska, and California (Biancata, 2013).

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 increase the allowance of more drug discounts for inpatient use at children's hospitals, cancer hospitals, critical care hospitals, and rural centers. This mandate increases the affordability for these patients who may need long-term care. Drug companies who participate in the Medicaid drug rebate program must sign pricing agreements for discounts on outpatient drugs purchased by qualified public health facilities. As of this writing, there are 14,500 facilities and 800 drug companies. The ACA will expand the participation to 5,000 additional facilities (Wakefield, 2010).

Title VIII—Community Living Assistance Services and Supports

- The establishment of the **CLASS Independence Benefit Plan**, which is a self-funded long term care insurance program for individuals with limited financial assistance.

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

- Requires employers to 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 the branded prescription pharmaceutical companies and exporters, medical device manufacturing industry, and the health insurance providers, according to market share. Also, there is an excise tax on indoor tanning services.
- Establishment of a **cafeteria plan** for healthcare benefits to employees, which enables 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 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. 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 \$2.9 billion a year thereafter. These fees will cost the industry approximately \$85 billion over a decade (Silverman, 2012). The same type of fee is applied to the health insurance industry in 2014. The fee will be \$8 billion and 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 is 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

- Development of a **Physician Compare website**.
- Development of a **Nursing Home Compare website**.
- Development of a **Cures Acceleration Network**.
- Permanent legal authority for the **Indian Health Care Improvement Act (IHCIA)**, which provides health care to American Indians and Alaska Natives.

Discussion

Located on the Centers for Medicare and Medicaid Services (CMS) website, the Physician Compare website is 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, 2013a). Also located on the CMS website, a Nursing Home Compare website was developed as a tool for consumers to research all nursing homes in the United States that are Medicare and Medicaid certified. A consumer can review the inspection findings from the past 3 years of these facilities. There are also Hospital, Home Health, and Dialysis Compare software tools. (Medicare.gov, 2013b).

Also, the National Institute of Health is establishing the Cures Acceleration Network, which is 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 National Institute of Health may award grants annually up to \$15 million to research these priority areas. In fiscal year 2013, the priority area of research is improving drug safety and expanding drug usage for different diseases.

The Indian Healthcare Improvement Act, originally passed in 1979 and had no appropriations since 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, 2010).

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 health-care, 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 argue that the act violates the Constitution because of the mandate of individual healthcare insurance coverage as well as infringes on state rights with the expansion of Medicaid (Arts, 2010). The 2012 U.S. Supreme Court Decision that supported 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 pre-existing 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 healthcare opportunities.

Although this legislation continues to be controversial, a system-wide effort needed to be implemented to curb rising healthcare costs. 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 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 enrollee (Youdelman, 2013). There are revenue provisions in place to offset some of the costs of this legislation. However, there are still components of the Act, although authorized, that have not yet been funded. During a recent House of Representatives vote, a bill was passed that defunded the ACA. The Senate has indicated it will not pass the bill and President Obama will veto the bill. With continued controversy, it will be difficult to assess quickly how cost effective and how impactful this health reform will be on improving the health care of U.S. citizens.

VOCABULARY

Affordable Care Act (ACA)	Donut hole
Cafeteria plan	Elder Justice Act
Centers for Consumer Information and Insurance Oversight	Essential Health Benefits (EHBs)
Center for Medicare and Medicaid Innovation	Health Insurance Marketplace
CLASS Independence Benefit Plan	Healthcare and Education Affordability Reconciliation Act of 2010
Community First Choice	Independence at Home program
Consumer Operated and Oriented Plans (CO-OPs)	Independent Payment Advisory Board
Cures Acceleration Network	Indian Health Care Improvement Act (IHCIA)

Life qualifying event	Prevention and Public Health Fund
National Health Care Workforce Commission	Primary Care Extension Program (PCEP)
National Prevention, Health Promotion, and Public Health Council	Public Plan Option
Nursing Home Compare website	Reinsurance Program
Patient-Centered Outcomes Research Institute	Small Business Health Options Program (SHOP)
Patient Protection and Affordable Care Act (PPACA)	Summary of Benefits and Coverage (SBC)
Physician Compare website	Working Group on Healthcare Quality

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NOTES

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.

American Health Benefit Exchanges: _____

Community First Choice: _____

Consumer Operated and Oriented Plan: _____

Elder Justice Act: _____

Independent Payment Advisory Board: _____

National Health Care Workforce Commission: _____

Nursing Home Compare website: _____

Physician Compare website: _____

Primary Care Extension Program: _____

Reinsurance Program: _____

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 their mission statement on their 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: _____

Importance of organization to U.S. health care:

<http://www.allhealth.org>

Organization Name: _____

Mission Statement:

Overview of Activities: _____

Importance of organization to U.S. health care:

<http://www.pnhp.org>

Organization Name: _____

Mission Statement:

Overview of Activities: _____

Importance of organization to U.S. health care:

<http://www.ahip.org>

Organization Name: _____

Mission Statement:

Overview of Activities: _____

Importance of organization to U.S. health care:

<http://www.hfma.org>

Organization Name: _____

Mission Statement:

Overview of Activities: _____

Importance of organization to U.S. health care:

<http://www.acep.org>

Organization Name: _____

Mission Statement:

Overview of Activities: _____

Importance of organization to U.S. health care:

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 ten title areas that you feel are important to improving our healthcare system. Defend your answer.

- (2) Do you feel that the mandate for individual health insurance coverage is constitutional? Defend your answer.

- (3) What do you think of the Nursing Home Compare and Physician Compare websites? Do you think they provide valuable information for consumers to support these important healthcare decisions?

- (4) Go to the website <http://www.healthcare.gov> and locate the new Patient Bill of Rights. Discuss five rights that are of interest to you and why.

- (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 they offer.

The Navigate Companion Website for this text is a great source for additional information on the U.S. healthcare system. You can gain a new perspective on many of the topics presented in this chapter by visiting <http://go.jblearning.com/Niles2e>. You'll find additional student activities, further reading, and interactive study tools that explore:

- Major Affordable Care Act initiatives
- Implementation of individual health insurance coverage mandate
- Role of Medicare and Medicaid in Affordable Care Act implementation
- And much more.

