

HEALTHCARE POLICY LEGISLATION AND ADMINISTRATION: PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

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INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA), commonly called Obamacare, or the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act (an amendment to the ACA signed March 30, 2010), it represents the most significant regulatory overhaul of the country's healthcare system since the passage of Medicare and Medicaid in 1965. Anywhere from thirty-eight to forty-eight million Americans do not have health insurance for a number of reasons. Yet the cost of these uninsured citizens is passed on to healthcare providers and ultimately consumers. More than one hundred billion dollars in health care costs annually is imposed on the present system by the uninsured. Most of this cost is manifested in higher health care costs and in some cases even the closure of hospitals. Thus the ACA is intended to prevent the uninsured from catastrophic medical expenses which not only devastate individual credit ratings, but also lead to bankruptcy and home foreclosures. In response to this, the ACA aims to increase the access, quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of

healthcare for individuals and the government. It provides a number of mechanisms – including mandates, subsidies, and insurance exchanges – to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of preexisting conditions or sex. Additional reforms aim to reduce costs and improve healthcare outcomes by shifting the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare. The Congressional Budget Office has projected that the ACA will lower both future deficits and Medicare spending.

On June 28, 2012, the United States Supreme Court upheld the constitutionality of most of the ACA in the case *National Federation of Independent Business v. Sebelius*. However, the Court held that states cannot be forced to participate in the ACA's Medicaid funding. Since the ruling, the law and its implementation have continued to face challenges in Congress, in federal courts, and from some state governments. Nevertheless, the ACA includes numerous provisions that take effect between 2010 and 2020. A grandfather clause exempts policies issued before 2010 from many of the changes to insurance standards, but are affected by other provisions. The most significant reforms include the following:

- ACA prohibits insurers from denying coverage to individuals regardless of pre-existing conditions, and a partial community rating requires insurers to offer the same premium to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tobacco use).
- Minimum standards for health insurance policies are established; no more junk insurance can be sold by private insurance companies.
- An individual mandate requires all individuals not covered by an employer sponsored health plan, Medicaid, Medicare,

or other public insurance programs (such as Tricare now Defense Health Agency for military and Department of Defense civilian personnel) to secure an approved private insurance policy or pay a penalty unless the applicable individual is a member of a recognized religious sect exempted by the Internal Revenue Service (IRS), or has a financial hardship based on a list of provisions provided by the IRS. Congress also included subsidies so that people with low-incomes can comply with the mandate.

- Health insurance exchanges will commence operation in every state. Each exchange will serve as an online marketplace where individuals and small businesses can compare policies and buy insurance (with a government subsidy if eligible).
- Low-income individuals and families whose income is above 100% and up to 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an exchange. Those from 133% to 150% of the poverty level will be subsidized such that their premium costs will be 3% to 4% of their annual income. In 2013, the subsidy would apply for incomes up to \$45,960 for an individual or \$94,200 for a family of four; consumers can choose to receive their tax credits in advance, and the exchange will send the money directly to the insurer every month. Small businesses will also be eligible for subsidies.
- Medical eligibility is expanded to include individuals and families with incomes up to 133% of the poverty level, and the CHIP (Children's Health Insurance Program/Medicaid) enrollment process is simplified. However, in *National Federation of Independent Business v. Sebelius*, the Supreme Court effectively ruled that states may opt-out of the Medicaid expansion, and several states have actually done so.
- Reforms to the Medicare payment system are meant to promote greater efficiency in the healthcare delivery

system by restructuring Medicare reimbursements from fee-for-service to bundled payments. Under the new payment system, a single payment is paid to a hospital and a physician group for a defined episode of care (such as a hip replacement) rather than individual payments to individual service-providers.

- Firms employing 50 or more people but not offering health insurance will also pay a shared responsibility requirement if the government has had to subsidize an employee's healthcare, usually through tax deductions. This is commonly known as the employer mandate.

In response to the historic legislation of the ACA, the following symposium, "Healthcare Policy Legislation and Administration: Patient Protection and Affordable Care Act of 2010," will attempt to provide a dialogue regarding the important facets of this legislation. Some of the articles deal with the Affordable Care Act directly, while others address ACA issues indirectly. The first article "Making Federalism Work? The Politics of Intergovernmental Collaboration and the Patient Protection Affordable Care Act," by Philip Rocco, examines how state-level administrators and state-federal collaboration implement health reform and how political conflict over the ACA reform may pose serious difficulties for future implementation efforts. Next, James Brasfield discusses the implications for Medicare in "Medicare's Future: Policy Ideas and the Coming Reform Debate," by examining the conceptual frameworks used to support or discredit Medicare based on the status quo, premium support, or consumer choice. James Dockins, Ramzi Abuzahrieh, and Martin Stack, in "Arabic Translation and Adaptation of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Satisfaction Survey Instrument," provides an innovative method for assessing healthcare networks with obvious implications for Obamacare. Opening part II of the

symposium, the fourth article, "Health Insurance Information-seeking Behaviors among Internet Users: An Exploratory Analysis to Inform Policies," by Erlyana Erlyana et al., explores the characteristics of internet users who seek health insurance information online. Then in "Prostate Cancer Screening: PSA Test Awareness among Adult Males," Michael Obana and Henry O'Lawrence analyze how prostate-specific antigen (PSA) tests need to be made more accessible to poor adult males who lack access to health care. Next, Sage Nakagawa and Henry O'Lawrence, in "Payer Source for Single, Elderly Women in Nursing Homes," critique and evaluate needed improvements payer source identification for single elderly women in nursing homes. Mark Portman and Edward Martin in "Medical Brigades and Global Health," argue for the need for increased support for international independent health care service based on sustainable development strategies in third world settings. Edward Martin then argues for increased support for the severely mentally ill homeless in "Affordable Housing, Homelessness, and Mental Health: What Health Care Policy Needs to Address." Finally, Christine Muller examines the success of sick leave in "California State University Catastrophic (CAT) Leave Donation Program."

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