

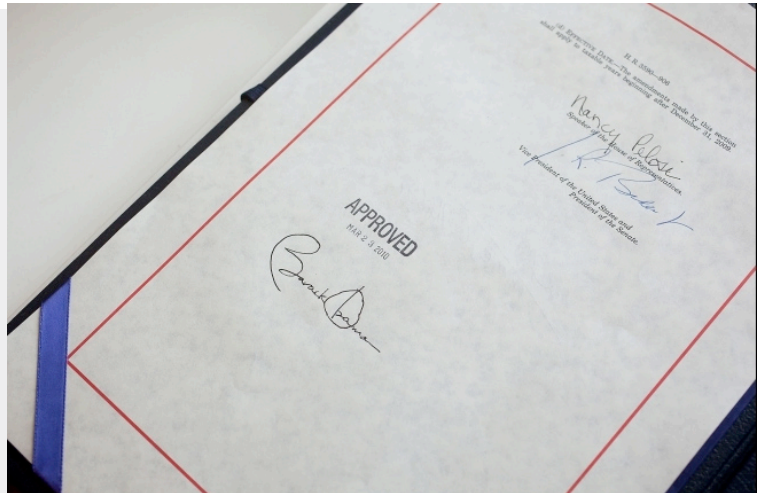
What You Need to Know About the Affordable Health Care Act of 2010

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Changes Which Have Been Implemented

2010

- * Small Businesses are eligible for tax credits which help them provide health insurance to their employees (Jan. 1).
- * States receive federal funding for covering certain individuals through Medicaid who were not previously covered (Jun. 1)
- * The Coverage gap is now closed
- * New resources and procedures are available to reduce fraud in Medicare, Medicaid and CHIP
- * A fund provides insurance for retirees between ages 55 and 65 until the Exchanges are opened (Jun. 1).
- * All of those with a preexisting condition who are either 19 and under or have been without insurance for 6 months now qualify for coverage under an abbreviated version of Guaranteed issue.(Jul. 1).
- * Young adults who are not offered insurance at work are allowed to remain on their parent's plan until they turn 26 years old. (Sept. 23).
- * New plans must offer certain preventative coverage without charging a deductible or co-pay (Sept. 23).
- * Insurance Companies are no longer able to rescind coverage (Sept 23).
- * Lifetime spending limits on essential benefits are prohibited (Sept. 23).
- * States which require insurance companies to justify their premium increases are eligible for \$250 million in grants
- * Financial incentives are provided for clinicians who work in primary care or in rural areas
- * A \$15 billion Prevention and Public Health Fund invests in proven prevention and public health programs



Chuck Kennedy

On March 23, 2010 the Patient Protection and Affordable Care Act was signed into law. On March 30, 2010 the Health Care and Education Reconciliation Act of 2010 was signed into law as an amendment to the PPACA. Many provisions of the Affordable Care Act had immediate impacts throughout the country. The changes affected all age groups, from children who were now offered insurance regardless of preexisting conditions, to college students who were allowed to remain on their parent's insurance plans, to early retirees who no longer have to battle the individual insurance market, to seniors who no longer fall in the infamous and now extinct coverage gap or donut hole of Medicare Part D. Many of the provisions of this new law are outlined here.

The types of provisions outlined in the ACA can be thought of as falling into one of two categories: efforts to provide better coverage and efforts to finance better coverage. The ACA offers resources for reducing waste and fraud, an effort that returned \$2.5 billion in FY 2009. The bill focuses on preventative care and accountable care in an attempt to reduce waste and demand for more expensive services.

The ACA also imposes greater regulations of health insurance companies. These companies will no longer be allowed to discriminate on the basis of sex or pre-existing condition, to impose spending limits for essential services, to rescind coverage or to preferentially and unclearly set premiums.

The ACA creates an environment in which insurance companies have to start working for the consumers and doctors get to focus on patient care instead of patient's ability to pay.

References for this article can be found online at tuftscopejournal.org.

Lauren-Elizabeth Palmer and Mark Leiserson are the Editors-in-Chief of TuftScope

2011

* Insurance companies will be required to spend at least 80% of individual and small business insurance premiums on providing health care services, and at least 85% of large-employer insurance premiums (Jan. 1)

* The Center for Medicare & Medicaid is established. The Center will focus on developing and identifying novel ways of providing more efficient and higher quality health care to patients. (Jan. 1)

* Seniors within the coverage gap will receive a 50% discount on Medicare Part D prescription drugs (Jan. 1)

* Home- and community-based services can be offered through Medicaid, diminishing the role of nursing homes and other institutional services

2012

* Incentives begin to encourage doctors to form "Accountable Care Organizations." These organizations' purpose is to allow doctors to better coordinate their efforts in providing quality health care. (Jan. 1)

* Federal health care programs are required to track and report racial, ethnic, and language statistics. These statistics will putatively be used to reduce health care-related disparities. (March 1st)

* Health care records begin their transition from paper to electronic (Oct 1).

* Hospitals performance becomes public data. This will allow for a better understanding between (and a stronger relationship) between costs and outcomes

2013

* States' preventative programs receive additional Medicaid funding to expand coverage and reduce costs (Jan 1).

* States' are required to pay 100% of Medicare payments for primary care services. These funds will be provided by the federal government (Jan 1).

* CHIP is extended for 2 years, funded by the federal government (Oct 1).

2014

* Health insurance exchanges open for business (Jan 1).

* Those who can afford health insurance are required to obtain health insurance, or pay a tax (Jan 1).

* Individuals can opt out of their employee coverage and take the funds the employer would have spent on health insurance to the Exchange (Jan. 1).

* Medicaid is expanded to all individuals under 133% of the poverty line, fully funded by the federal government for the first 3 years (Jan 1).

* Tax credits are provided for those between 100-400% of the poverty line in order to make health insurance more affordable (Jan 1).

* Limits on the annual payouts of insurance coverage are revoked (Jan 1)

* Insurers cannot deny coverage based on gender or pre-existing conditions (Jan 1)

2015

* Physicians are paid based on the outcomes of the care they provide, rather than the volume (Jan 1).

TERMS DEFINED

Accountable Care Organizations: a model which will provide financial incentives to those who provide good, quality care and Medicare beneficiaries

CHIP: The Children's Health Insurance Program which provides assistance to all uninsured children and teenagers who do not qualify for Medicaid, regardless of parent's income level.

Coverage Gap: the gap in coverage which exists in the Medicare Part D program, currently participants do not pay for the first few thousand dollars of prescription drugs, but do resume paying once they exceed this sum. The consumer pays 100% of prescription drug costs until they reach the catastrophic coverage level, in which case Medicare Part D resumes.

Health Insurance Exchanges: a set of state regulated and standard health insurance programs which is available to individuals.