An Overview of the Patient Protection and Accountable Care Act

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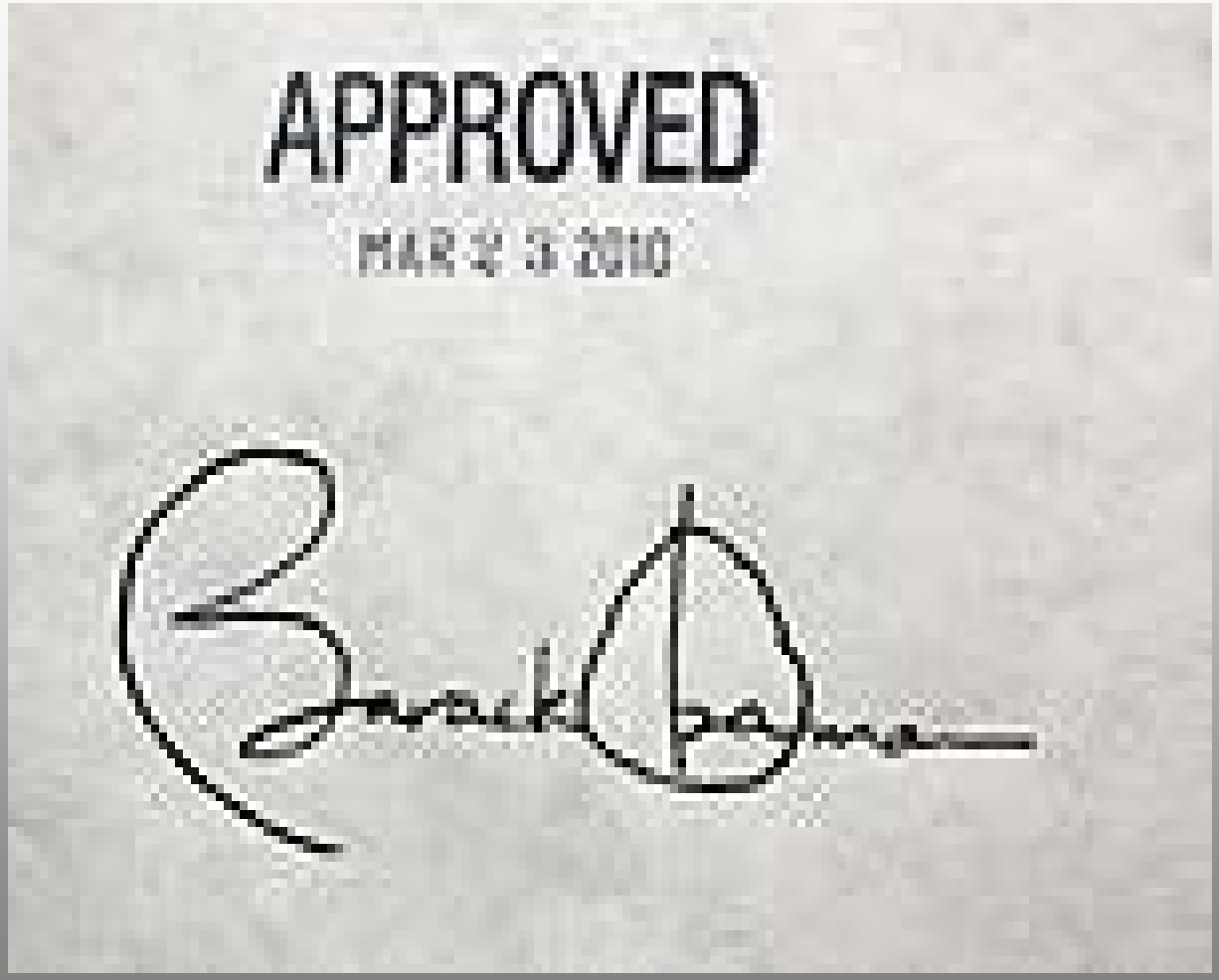
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Basic Goals of the PPACA

Address the triple aim of:

- Improved population health outcomes
- Increased customer satisfaction
- Reduced cost

DM Berwick, TW Nolan, J Whittington. “The Triple Aim: care, health, and cost.” Health Affairs, 2008.

PPACA Funding

Summary of tax increases:

- Broadened Medicare tax base for high-income taxpayers: $210.2 billion
- Annual fee on health insurance providers: $60 billion
- 40% excise tax on health coverage in excess of $10,200/$27,500: $32 billion
- Imposed annual fee on manufacturers and importers of branded drugs: $27 billion

PPACA Funding

- Imposed 2.3% excise tax on manufacturers and importers of certain medical devices: $20 billion
- Raised 7.5% Adjusted Gross Income floor on medical expenses deduction to 10%: $15.2 billion
- Limited contributions to flexible spending arrangements in cafeteria plans to $2,500: $13 billion
- All other revenue sources: $14.9 billion
- Original budget estimates included a provision to require information reporting on payments to corporations, which had been projected to raise $17 billion, but the provision was repealed.

PPACA Implementation Timelines
Effective at Enactment

- The Food and Drug Administration is now authorized to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use;
- The Medicaid drug rebate for brand name drugs is increased to 23.1% (more or less);
- A non-profit Patient-Centered Outcomes Research Institute is established,; independent from government, to undertake comparative effectiveness research.

PPACA Implementation Timelines Effective at Enactment

- Creation of task forces on Preventive Services and Community Preventive Services;
- The Indian Health Care Improvement Act was reauthorized and amended;
- Chain restaurants and food vendors with 20 or more locations are required to display the caloric content of their foods on menus, drive-through menus, and vending machines.

PPACA Implementation Timelines
Effective June 21, 2010

- Adults with pre-existing conditions became eligible to join a temporary high-risk pool, which was superseded by the health care exchange in 2014. To qualify for coverage, applicants must have a pre-existing health condition and have been uninsured for at least the past six months. There is no age requirement. The new program sets premiums as if for a standard population and not for a population with a higher health risk. Allows premiums to vary by age, geographic area, and family composition. Limit out-of-pocket spending to $5,950 for individuals and $11,900 for families, excluding premiums.

PPACA Implementation Timelines
Effective July 1, 2010

- Established, within the Department of Health and Human Services (HHS), a council to be known as the *National Prevention, Health Promotion and Public Health Council* to help begin to develop a National Prevention and Health Promotion Strategy.
- A 10% tax on indoor tanning took effect.

PPACA Implementation Timelines Effective September 23, 2010

- Insurers are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays, in new policies.[57]
- Dependents (children) are permitted to remain on their parents' insurance plan until their 26th birthday; includes dependents that no longer live with their parents, are not a dependent on a parent's tax return, are no longer a student, or are married.
- Insurers are prohibited from excluding pre-existing medical conditions (except in grandfathered individual health insurance plans) for children under the age of 19.

PPACA Implementation Timelines
Effective September 23, 2010

- Insurers are prohibited from charging co-payments, co-insurance, or deductibles for Level A or Level B preventive care and medical screenings on all *new* insurance plans;
- Individuals affected by the Medicare Part D coverage gap received a $250 rebate, and 50% of the gap was eliminated in 2011. The gap will be eliminated by 2020.
- Insurers' abilities to enforce annual spending caps was restricted, and completely prohibited by 2014.

PPACA Implementation Timelines
Effective September 23, 2010

- Insurers were prohibited from dropping policyholders when they get sick;
- Insurers were required to reveal details about administrative and executive expenditures;
- Insurers were required to implement an appeals process for coverage determination and claims on all new plans;
- Enhanced methods of fraud detection were implemented.

PPACA Implementation Timelines
Effective September 23, 2010

- Medicare was expanded to small, rural hospitals/facilities;
- Medicare patients with chronic illnesses must be monitored/evaluated on a 3 month basis for coverage of the medications for treatment of such illnesses;
- Companies which provide early retiree benefits for individuals aged 55–64 became eligible to participate in a temporary program which reduced premium costs.

PPACA Implementation Timelines Effective September 23, 2010

- A new website was installed by the Secretary of Health and Human Services which provided consumer insurance information for individuals and small businesses in all states.
- A temporary credit program was established to encourage private investment in new therapies for disease treatment and prevention.

PPACA Implementation Timelines Effective January 1, 2011

- Insurers must spend a certain percent (80%) of premium dollars on eligible expenses, 2016 increased to 85%;
- CMS developed the Center for Medicare and Medicaid Innovation (CMMI) and overseeing the testing of innovative payment and delivery models including Accountable Care Organizations (ACOs) and the Health Care Innovation Challenge Award Program;
- Flexible spending accounts, health reimbursement accounts and health savings accounts cannot be used to pay for over-the-counter drugs, purchased without a prescription, except insulin.

PPACA Implementation Timelines Effective January 1, 2012

- Employers must disclose the value of the benefits they provided beginning in 2012 for each employee's health insurance coverage on the employees' annual Form W-2's.
- New tax reporting changes were to come in effect to prevent tax evasion by corporations.
- In April 2011, Congress passed and President Obama signed the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 repealing this provision, because it was burdensome.

PPACA Implementation Timelines
Effective by August 1, 2012

All new plans covered certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. Women's Preventive Services – including well-woman visits, support for breastfeeding equipment, contraception and domestic violence screening – will became covered without cost sharing.

PPACA Implementation Timelines Effective by January 1, 2013

- Income from self-employment and wages of single individuals in excess of $200,000 annually became subject to an additional tax of 0.9%. The threshold amount is $250,000 for a married couple filing jointly (threshold applies to joint compensation of the two spouses), or $125,000 for a married person filing separately;
- Additional tax of 3.8% was applied to the lesser of net investment income or the amount by which adjusted gross income exceeds $200,000 ($250,000 for a married couple filing jointly; $125,000 for a married person filing separately.)

PPACA Implementation Timelines Effective by January 1, 2014

- Insurers are prohibited from discriminating against or charging higher rates for any individuals based on pre-existing medical conditions;
- Impose an annual penalty of $95, or up to 1% of income, whichever is greater, on individuals who do not secure insurance; this will rise to $695, or 2.5% of income, by 2016. This is an individual limit; families have a limit of $2,085. Exemptions to the fine in cases of financial hardship or religious beliefs are permitted;
- Insurers prohibited from establishing annual spend caps.

PPACA Implementation Timelines
Effective by January 1, 2014

- Expand Medicaid eligibility; all individuals with income up to 133% of the poverty line qualify for coverage;
- Two years of tax credits will be offered to qualified small businesses. The small business must have an average payroll per full time equivalent ("FTE") employee, excluding the owner of the business, of less than $25,000 and have fewer than 11 FTEs. The subsidy is reduced by 6.7% per additional employee and 4% per additional $1,000 of average compensation. As an example, a 16 FTE firm with a $35,000 average salary would be entitled to a 10% premium subsidy.

PPACA Implementation Timelines Effective by January 1, 2014

- Imposed a $2,000 per employee tax penalty on employers with more than 50 employees who do not offer health insurance to their full-time workers (as amended by the reconciliation bill).[85]
- Set a maximum of $2,000 annual deductible for a plan covering a single individual or $4,000 annual deductible for any other plan (see 111HR3590ENR, section 1302). These limits can be increased under rules set in section 1302.

PPACA Implementation Timelines
Effective by January 1, 2014

- The CLASS Act provision would have created a voluntary long-term care insurance program - dropped in 2011;
- Pay for new spending, in part, through spending and coverage cuts in Medicare Advantage, slowing the growth of Medicare provider payments (in part through the creation of a new Independent Payment Advisory Board), reducing Medicare and Medicaid drug reimbursement rate, cutting other Medicare and Medicaid spending. (These provision were implemented by MACRA (see below);
- Revenue increases from a new $2,500 limit on tax-free contributions to flexible spending accounts (FSAs).

PPACA Implementation Timelines Effective by January 1, 2014

- Establish health insurance exchanges, and subsidization of insurance premiums for individuals in households with income up to 400% of the poverty line. To qualify for the subsidy, the beneficiaries cannot be eligible for other acceptable coverage. Section 1401(36B) of PPACA explains that the subsidy will be provided as an advanceable, refundable tax credit and gives a formula for its calculation. Refundable tax credit is a way to provide government benefit to people even with no tax liability (example: Earned Income Credit).

PPACA Implementation Timelines Effective by January 1, 2014

- Members of Congress will only be offered plans through the exchange or plans established by the bill;
- A new excise tax that is applicable to pharmaceutical companies, based on the market share of the company;
- Most medical devices become subject to a 2.3% excise tax. The tax is expected to yield up to $14.3 billion in annual revenue;
- The qualifying medical expenses deduction for Schedule A tax filings increases from 7.5% to 10% of income.

PPACA Implementation Timelines

Other Investments:

- Fully Integrated Dual Advantage Plans (FIDAs) to replace Special Needs Plans;
- Coop Plans for self-employed workers
- Delivery System Redesign Incentive Program (DSRIP, 2013), waiver funds to create Performing Provider Systems. Currently operating in 6 states;
- Balancing Incentive Program (BIP; 2014), to fund redesign of long-term care system.

PPACA Implementation Timelines Effective by January 1, 2015

- Physicians' payment were expected to be modified to be based on the quality of care, not the volume. This goal was incorporated into the Medicare and Children's Health Insurance Reauthorization Act (MACRA, 2016) which also repealed the Sustainable Growth Formula.

PPACA Implementation Timelines
Effective by January 1, 2017

- A state may apply to the Secretary of Health & Human Services for a "waiver for state innovation" provided that the state passes legislation implementing an alternative health care plan meeting certain criteria. The decision of whether to grant the waiver is up to the Secretary (who must annually report to Congress on the waiver process) after a public comment period. (see State Innovation Models (SIM) program, currently operating on 28 states).

PPACA Implementation Timelines
Effective by January 1, 2018

- All *existing* health insurance plans must cover approved preventive care and checkups without co-payment;
- A new 40% excise tax on high cost ("Cadillac") insurance plans on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (individual coverage), and it is increased to $30,950 (family) and $11,850 (individual) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation; employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

PPACA Implementation Timelines
Effective by January 1, 2020

- The Medicare Part D coverage gap (aka "donut hole") would be completely phased out and hence closed.

Deficit Reduction Under PPACA

The 2011 comprehensive CBO estimate projected a net deficit reduction of more than $200 billion during the period 2012-2021. CBO estimated in March 2011 that for the 2012-2021 period, the law would result in net receipts of $813 billion, offset by $604 billion in outlays, resulting in a $210 billion reduction in the deficit.

Summary: Major PPACA Themes

A 10-year road map to health care transformation:

- Expanded access through Medicaid expansion, Health Care Exchanges and other means
- Redefined the role of the regulator (Federal and State governments).
- Insurance reform including an expanded role of insurance companies and delivery systems as fiscal intermediaries;
- Shifted control to states through waivers for innovation;
- Created new models which reduce fee-for-service and move toward value-based compensation.