

- The tendency of market systems to maximize consumption

Thus we see governments adopting a confusing and seemingly inconsistent array of measures designed to deal with these concerns. For example, resources go out to enhance access to services, expanding the supply of providers and technology, at the same time that other programs seek to constrain consumption. No wonder professionals caught up in this maelstrom sometimes feel discouraged. Still, most professionals persevere and reap the intellectual and personal rewards of their craft. They continue to balance the interests of their patients and their organizations successfully.

All of this reflects the Chinese curse: “May you live in interesting times.”

Case 5 Key Features of the Affordable Care Act, by Year (Abridged from HealthCare.gov)

The following time line describes the key features of the ACA and the year of implementation as provided by the HealthCare.gov website (HealthCare.gov, 2013).

2010

New Consumer Protections

- **Putting information for consumers online.** The law provides for sites where consumers can compare health insurance coverage options and pick the coverage that works for them.
- **Prohibiting denying coverage of children based on preexisting conditions.** New rules to prevent insurance companies from denying coverage to children under the age of 19 due to a preexisting condition.
- **Prohibiting insurance companies from rescinding coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer’s application and use this error to deny payment for services when he or she got sick. The health care law makes this illegal.
- **Eliminating lifetime limits on insurance coverage.** Insurance

companies are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.

- **Regulating annual limits on insurance coverage.** Under the law, insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans.
- **Appealing insurance company decisions.** The law provides consumers with a way to appeal coverage determinations or claims to their insurance company and establishes an external review process.
- **Establishing consumer assistance programs in the states.** Under the law, states that apply receive federal grants to help set up or expand independent offices to help consumers navigate the private health insurance system.

Improving Quality and Lowering Costs

- **Providing small business health insurance tax credits.** Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25% credit.
- **Offering relief for 4 million seniors who hit the Medicare prescription drug "donut hole."** An estimated 4 million seniors will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. Each eligible senior will receive a one-time, tax-free \$250 rebate check.
- **Providing free preventive care.** All new plans must cover certain preventive services, such as mammograms and colonoscopies, without charging a deductible, copay, or coinsurance.
- **Preventing disease and illness.** A new \$15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy—from

smoking cessation to combating obesity.

- **Cracking down on health care fraud.** The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and Children's Health Insurance Program (CHIP).

Increasing Access to Affordable Care

- **Providing access to insurance for uninsured Americans with preexisting conditions.** The Pre-Existing Condition Insurance Plan provides new coverage options to individuals who have been uninsured for at least 6 months because of a preexisting condition. States have the option of running this program in their state. If a state chooses not to do so, a plan will be established by the Department of Health and Human Services in that state.
- **Extending coverage for young adults.** Young adults will be allowed to stay on their parents' plan until they turn 26.
- **Expanding coverage for early retirees.** To preserve employer coverage for early retirees until more affordable coverage is available through the new exchanges by 2014, the new law creates a \$5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents.
- **Rebuilding the primary care workforce.** There are new incentives in the law to expand the number of primary care doctors, nurses, and physician assistants. These include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses receiving payments made under any state loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments.
- **Holding insurance companies accountable for unreasonable rate hikes.** The law allows states that have, or plan to implement, measures that require insurance companies to justify their

premium increases will be eligible for \$250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance exchanges in 2014.

- **Allowing states to cover more people on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents.
- **Increasing payments for rural health care providers.** The law provides increased payment to rural health care providers to help them continue to serve their communities.
- **Strengthening community health centers.** The law includes new funding to support the construction of and expand services at community health centers.

2011

Improving Quality and Lowering Costs

- **Offering prescription drug discounts.** Seniors who reach the coverage gap will receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Over the next 10 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.
- **Providing free preventive care for seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans, for seniors on Medicare.
- **Improving health care quality and efficiency.** The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. Additionally, by January 1, 2011, the Department of Health and Human Services (HHS) will submit a national strategy for quality improvement in health care, including by these programs.
- **Improving care for seniors after they leave the hospital.** The Community Care Transitions Program will help high-risk

Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities.

- **Introducing new innovations to bring down costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the president aimed at extending the life of the Medicare Trust Fund. The board is expected to focus on ways to target waste in the system and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care.

Increasing Access to Affordable Care

- **Increasing access to services at home and in the community.** The Community First Choice Option allows states to offer home and community-based services to disabled individuals through Medicaid rather than institutional care in nursing homes.

Holding Insurance Companies Accountable

- **Bringing down health care premiums.** The law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers.
- **Addressing overpayments to big insurance companies and strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over \$1,000 more per person on average than is spent per person in traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to

Medicare Advantage plans that provide high-quality care.

2012

Improving Quality and Lowering Costs

- **Linking payment to quality outcomes.** The law establishes a hospital value-based purchasing (VBP) program in traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health care–associated infections, and patients’ perception of care.
- **Encouraging integrated health systems.** The new law provides incentives for physicians to join together to form ACOs. These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions. If ACOs provide high-quality care and reduce costs to the health care system, they can keep some of the money that they have helped save.
- **Reducing paperwork and administrative costs.** The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information.
- **Understanding and fighting health disparities.** To help understand and reduce persistent health disparities, the law requires any ongoing or new federal health program to collect and report racial, ethnic, and language data.

Increasing Access to Affordable Care

- **Providing new, voluntary options for long-term care insurance.** The law creates a voluntary long-term care insurance program—called CLASS—to provide cash benefits to adults who become disabled. [Note: On October 14, 2011, Secretary Sebelius transmitted a report and letter to Congress stating that the department does not see a viable path forward for CLASS implementation at this time.]

2013

Improving Quality and Lowering Costs

- **Improving preventive health coverage.** To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost.
- **Expanding authority to bundle payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare.

Increasing Access to Affordable Care

- **Increasing Medicaid payments for primary care doctors.** The act requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government.
- **Open enrollment in the health insurance marketplace begins.** Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and competitive insurance marketplace.

2014

New Consumer Protections

- **Prohibiting discrimination due to preexisting conditions or gender.** The law prohibit(s) insurance companies from refusing to sell coverage or renew policies because of an individual’s preexisting conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status.

- **Eliminating annual limits on insurance coverage.** The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.
- **Ensuring coverage for individuals participating in clinical trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

Improving Quality and Lowering Costs

- **Making care more affordable.** Tax credits will become available for people with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. (In 2010, 400% of the poverty line comes out to about \$43,000 for an individual or \$88,000 for a family of four.) The tax credit is advanceable. It is also refundable. Individuals may also qualify for reduced cost-sharing (copayments, coinsurance, and deductibles).
- **Establishing the health insurance marketplace.** If your employer does not offer insurance, you will be able to buy it directly in the health insurance marketplace. Individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and competitive insurance marketplace. The marketplace will offer you a choice of health plans that meet certain benefits and cost standards.
- **Increasing the small business tax credit.** In this phase, the credit is up to 50% of the employer's contribution to provide health insurance for employees. There is also up to a 35% credit for small nonprofit organizations.

Increasing Access to Affordable Care

- **Increasing access to Medicaid.** Americans who earn less than 133% of the poverty level (approximately \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100% federal funding for the first 3 years to support this expanded coverage, phasing to

90% federal funding in subsequent years.

- **Promoting individual responsibility.** Under the law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption.

2015

Improving Quality and Lowering Costs

- **Paying physicians based on value not volume.** Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.

Source: Modified from: Key Features of the Affordable Care Act by Year. U.S. Department of Health & Human Services. <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html>

Discussion Questions

1. The material presented in this case was abridged from a document provided by the Obama administration on the [HealthCare.gov](http://www.healthcare.gov) website. Does it fairly represent the key issues in the law?
2. What do you think was behind the phasing in of the various provisions of the law? Would you have phased them in differently?
3. How do these provisions represent the three visions of how health policy should work?
4. How has the implementation of this time line changed over time:
 - a. After the Supreme Court ruled on the constitutionality of various provisions of the ACA in 2013,
 - b. As the Administration experienced problems with the computer systems it had put in place, and
 - c. As various groups requested temporary or permanent relief from the law's implementation requirements?