The Affordable Care Act – The Federal Perspective

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What is the overall effect of the Affordable Care Act (ACA)

A major goal of the ACA is to better integrate and coordinate health care delivery and financing by expanding the level of health care provided under an Accountable Care Organizations (ACO) umbrella. ACOs are designed to align provider incentives with provision of quality and coordinated care and to shift reimbursement away from volume of services toward health outcomes and quality. ACOs are also meant to improve the infrastructure underlying care delivery. To date, the ACO models that have emerged have largely focused on health care services for the Medicare population. Expert analysis recently completed indicates that there are very few ACO type models of care that include any dental services. Looking forward, it is uncertain when and to what degree ACOs will integrate dental care delivery and reimbursement as part of the core health care services they provide.

Establishing the Health Insurance Marketplace. When key parts of the health care law take effect in 2014, there will be a new way for individuals, families and small businesses to get health insurance. Beginning Oct. 1, 2013, individuals in every state will be able to shop for health insurance and compare plans through the Marketplace.

Increasing Access to Medicaid. The Affordable Care Act fills gaps in coverage for the poorest Americans by giving states the option to expand Medicaid to individuals under 65 years of age with income below 133 percent of the federal poverty level (FPL) (approximately $14,000 for an individual and $29,000 for a family of four) beginning in January 2014. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in subsequent years. In addition, Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment will be much simpler and will be coordinated with the Marketplace.

Providing new coverage options for young adults

Health plans are now required to allow parents to keep their children under age 26

without job-based coverage on their family coverage, and, thanks to this provision, 3.1 million young people have gained coverage nationwide

Making prescription drugs affordable for seniors

The Affordable Care Act makes prescription drug coverage (Part D) for people with Medicare more affordable. It does this by gradually closing the gap in drug coverage known as the "donut hole." Since the enactment of the law, 6.1 million Americans with Medicare who reached the donut hole have saved over $5.7 billion on prescription drugs. Nationwide, drug savings of $2.5 billion in 2012 were higher than the $2.3 billion in savings for 2011. In 2012, people with Medicare in the “donut hole” received a 50 percent discount on covered brand name drugs and 14 percent discount on generic drugs. And thanks to the Affordable Care Act, coverage for both brand name and generic drugs will continue to increase over time until the coverage gap is closed.

Covering preventive services with no deductible or co-pay

The health care law requires many insurance plans to provide coverage without cost sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults.

In 2011 and 2012, 71 million Americans with private health insurance gained preventive service coverage with no cost-sharing. For policies renewing on or after August 1, 2012, women can now get coverage without cost-sharing of even more preventive services they need.

The Affordable Care Act is also removing barriers for people with Medicare. With no deductibles or co-pays, cost is no longer a barrier for seniors and people with disabilities who want to stay healthy by detecting and treating health problems early. In 2012 alone, an estimated 34.1 million people with Medicare benefited from Medicare’s coverage of preventive services with no cost-sharing.

Providing better value for your premium dollar through the 80/20 Rule

Under the new health care law, insurance companies must provide consumers greater value by spending generally at least 80 percent of premium dollars on health care and quality improvements instead of overhead, executive salaries or marketing. If they don’t, they must provide consumers a rebate or reduce premiums.

Removing lifetime limits on health benefits

The law bans insurance companies from imposing lifetime dollar limits on health

benefits – freeing cancer patients and individuals suffering from other chronic diseases from having to worry about going without treatment because of their lifetime limits.

N**ew coverage options for individuals with pre-existing conditions**.

Pre-Existing Condition Insurance Plan (PCIP) makes health coverage available to individuals who are a U.S. citizen or reside in the U.S. legally, who have been denied health insurance because of a pre-existing condition, *and* who have been uninsured for at least six months. On February 16, 2013, the federally-run Pre-Existing Condition Insurance Plan (PCIP) suspended acceptance of new enrollment applications until further notice. However, the state operated PCIP is still accepting applications.

Strengthening partnerships with New Mexico

The law gives states support for their work to build the health care workforce, crack down on fraud, and support public health. These partnerships help ensure that health care providers are working where they are needed most - in both urban and rural areas.

Health Insurance Exchanges

Exchanges must be in place in time to begin enrolling beneficiaries by October, 2013. Initially, the exchange will be available to individuals and small businesses only allowing the purchasers to select from various private health care plans. Under the ACA, people with incomes between 100-400 percent of the FPL are eligible to receive federally subsidized coverage through the exchange.

A key aspect of the ACA is the individual mandate to obtain health insurance covering 'essential' health benefits. To achieve this goal, the law ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), must offer "essential health benefits." Essential health benefits must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care

5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

Although the law includes pediatric dental care in a list of essential health benefits to be provided by small and individual group health plans, dental care for adults is not included in that essential benefit package. To ensure a consistent level of consumer protections, stand-alone dental plans must offer the pediatric oral essential health benefit without annual and lifetime limits.

Top 7 things you can do now to get ready to purchase on the Exchange

1. **Learn about different types of health insurance.** Through the Marketplace, you'll be able to choose a health plan that gives you the right balance of costs and coverage.
2. **Make a list of questions you have before it's time to choose your health plan.** For example, "Can I stay with my current doctor?" or "Will this plan cover my health costs when I'm traveling?"
3. **Make sure you understand how insurance works, including deductibles, out-of-pocket maximums, copayments, etc.** You will want to consider these details while you're shopping around. Visit www.healthcare.gov/Insurance Basics to learn more about how insurance works.
4. **Start gathering basic information about your household income.** Most people will qualify to get a break on costs, and you'll need income information to find out how much you are eligible to receive.
5. **Set your budget.** There will be different types of health plans to meet a variety of needs and budgets, and breaking them down by cost can help narrow your choices.

6. **Find out from your employer whether they plan to offer health insurance, especially if you work for a small business.**

7. **Explore current options.** You may be able to get help with insurance now, through existing programs or changes that are in effect already from the new health care law. Use our resources to get information about health insurance for adults up to age 26, children in families with limited incomes (CHIP), and Medicare for people who are over 65 or have disabilities.

Medicaid

The ACA provides for the expansion of Medicaid to cover people with incomes below 138 percent of the federal poverty level (FPL). The federal government will pickup 100 percent of the cost of covering this additional population initially and 90 percent of the cost long term.

As Medicaid programs and providers prepare to cover more patients in 2014, 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.

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.

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. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.

Taxes and Limits on Tax Preferred Accounts

Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. Starting in 2013, the FSA set-aside will be limited to $2,500 a year and increased annually by a cost-of-living adjustment.

Small Businesses

Small employers have a tough time finding and affording coverage that meets the needs of their employees. Starting in 2014, Small Businesses will have more choice and control over their health insurance spending through the Small Business Health Options Program (SHOP), a new program designed to simplify the process of finding health insurance for your small business.

Small Businesses will control the coverage you offer

Small Business owners will choose the level of coverage you'll offer, and define how much you'll contribute towards your employees' coverage.

Access to tax benefits

Small Businesses will have exclusive access to an expanded Small Business Healthcare Tax Credit. This tax credit covers as much as 50% of the employer contribution toward premium costs for eligible employers who have low- to moderate-wage workers.

When Small Business owners who get insurance through the SHOP, makes it easy for you take advantage of other tax breaks too including the chance for you and your employees to use pre-tax dollars to make your premium payments.

New consumer protections

Small Business owners and their employees will also benefit from new protections that help you get real value for your premium dollars. There are new limits on the higher premiums insurers can charge businesses with older employees, and an employee with high health care costs no longer increases your group's premium. There are also new limits on the share of premiums going to insurers' profits and administrative costs.

Insurance plans run by private companies

The health insurance plans available in the SHOP will be run by private health insurance companies, the same way small group plans are run now. All plans will offer the same benefits as a “typical” employer plan, including real protection against financial catastrophe.

Plans will present their cost and coverage information in a standard format, using plain language that’s clear and easy for you to understand. You and your employees will be able to easily compare plans based on price, coverage, quality and other features that are important to you.

Use your broker, or shop on your own

You can use your existing insurance broker to access the SHOP, or you can shop for plans yourself, without a broker. You can review pricing and coverage in apples-to-apples comparisons, complete a single application, and choose the level of coverage that works for your budget, your business, and your employees.

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