AIDS Policy News
From Albany, New York City and Washington

Published by:
VILLAGECARE

March 30, 2010
Volume 2, Issue 3

Health Care Reform Becomes the Law of the Land

Finally, fourteen months after Barack Obama was sworn into office and over one hundred years after Teddy Roosevelt campaigned for President promising national health insurance, President Obama signed into law a major overhaul of the nation's health care system that will offer almost universal coverage. The path toward enacting reform was a nail-biting process for most, with Republicans united against the proposed changes and Democrats struggling, despite their larger majorities in both chambers, to keep enough of their members supportive to overcome Republican opposition. Considering the numerous false starts to enacting reform over the past century, many supporters did not believe this day would ever come.

Presidents Who Proposed National Health Insurance

Theodore Roosevelt
1901-1909

Franklin D. Roosevelt
1933-1945

Harry Truman
1945-1953

Richard Nixon
1969-1974

Jimmy Carter
1977-1981

Bill Clinton
1993-2001

How Reform Was Achieved

On March 23, 2010, President Obama signed into law the "Patient Protection and Affordable Care Act", which is the U.S. Senate's version of health care reform. Until this March, two health reform bills had been passed -- one passed in the Senate and another, much different bill, in the House of Representatives. Congress needed to find a way to pass the exact same bill in both chambers, all while overcoming Republican opposition at every step in the legislative process. Democratic leadership realized that the only way this was going to happen was for the House to adopt the Senate's bill. The Senate passed their version of health reform, over the strong objection of Republicans, before the election of Republican Scott Brown in Massachusetts, replacing the seat held for decades by Senator Edward Kennedy. That election denied Democrats in the Senate the crucial 60 votes needed to prevent a filibuster of the legislation. The only viable option left was for the House to act on the Senate's bill, thereby sending it to the President for his signature. On

President Obama signing Health Care Reform Bill.

March 21st, the House passed the Senate version of health insurance reform legislation by a vote of 219 to 212—sending it to the President for his signature.

At the same time, many House Democrats were supportive of the Senate bill only if a reconciliation bill was also passed that made improvements to the Senate legislation. Shortly after the House passed the Senate bill, a reconciliation bill was pushed through both chambers. Unlike most legislation, a reconciliation bill, which makes changes to the federal budget, only needs a majority of 51 Senators, not 60, for passage. In essence, the reconciliation bill made changes to health care reform that impact on the federal budget, such as taxes, fees and any added costs or savings to the U.S. government. Efforts to include provisions in reconciliation that did not impact on the federal budget were not approved by the Senate parliamentarian. The House also passed the Reconciliation bill to improve the Senate bill by a vote of 220 to 211 on March 21. The Senate passed reconciliation on March 25 by a vote of 56-43, with two small changes, and it returned to the House later that evening. The House then passed the amended reconciliation by a vote of 220-207. The reconciliation bill was then signed by the President on Tuesday, March 30.

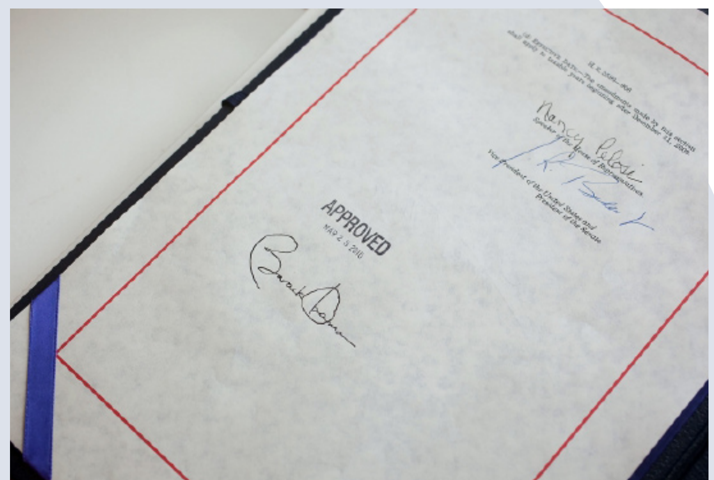
Supporters of reform, including those in the HIV and disability community, were thrilled that both the Senate bill and the reconciliation bill passed both chambers and were signed by the President. Stated President Obama during the signing ceremony: "And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care. And it is an extraordinary achievement that has happened because of all of you and all the advocates all across the country."

However, before the ink was even dry on the President's signing pen, Republicans were announcing new efforts to stop reform. Attorneys generals from several states announced their intention to file lawsuits against the law on constitutional grounds, and Republican congressmen were busy introducing bills to repeal the law. The legal challenges, while quickly dismissed by the White House, are not frivolous. The attorneys general argue that the individual mandate, forcing individuals to purchase health insurance or otherwise face a fine, is an abuse of Congress's constitutional power "to regulate Commerce . . . among the several states." They argue that a person who declines to buy insurance is not engaged in interstate commerce and therefore this oversteps Congress's constitutional authority. This issue is bound to wind up before the U.S. Supreme Court.

What Health Reform Will Do

Overall, the Patient Protection and Affordable Care Act will require most U.S. citizens and legal residents to have health insurance or purchase it. In order to accomplish this, state based exchanges will be created where individuals can purchase insurance, and subsidies, based on income, will be made available to help with premiums. Separate exchanges will be created for small businesses to purchase insurance. Medicaid will be expanded, thus ensuring that low-income individuals have coverage. And a series of new regulations will be imposed on the health insurance industry that clamp down on abuses.

The law, when fully implemented in 2019, promises to expand coverage to an additional 32 million Americans who are currently uninsured. The U.S. Congressional Budget Office estimates the program will cost $940 billion over ten years.



The costs are offset by savings in Medicare and Medicaid, a new tax on high-cost insurance and some other taxes and fees.

The roll-out of the legislation will occur in stages; most of the changes will not happen until later years, with 2014 being the major year that a large portion of the law goes into effect. In 90 says, a handful of insurance regulatory issues will kick in, as well as some temporary insurance provisions for those who are the worst off.

Impact on Individuals

Starting in 90 days, the U.S. Department of Health and Human Services (HHS) will create a temporary high-risk insurance pool for people who have been uninsured for six months and have a pre-existing health condition. Premiums will be offered at a subsidized rate, so theoretically individuals who desperately need insurance should be able to afford the premiums. There will also be a temporary reinsurance program to provide reimbursement to participating employment-based plans to partially cover the cost of providing health benefits to retirees between the ages of 55 and 64, and their families. Both programs end in 2014 when new "health insurance exchanges" will become operational.

Also beginning in 90 days, all individual and group policies must provide dependent coverage for children up to age 26.

Beginning in 2014, U.S. citizens and legal residents will be mandated to have qualifying health insurance coverage or pay a penalty. Some exceptions will be allowed for financial hardship, and religious objections, and for American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, and those for whom the lowest cost plan option exceeds 8 percent of an individual's income. This is a model that is used in many Western European countries, including the Netherlands and Switzerland.

In order to help individuals pay for health insurance premiums, credits will be made available, on a sliding scale based on income, to pay for insurance through the insurance exchanges. Only U.S. citizens and legal residents will be eligible for the credits. Individuals and families with incomes at 133 percent of the federal poverty level will pay two percent of their income toward premiums. Under the sliding scale, this expands gradually to 9.8 percent of income to those at 400 percent of the federal poverty level.

Subsidies will be provided to help pay for cost-sharing in insurance plans (deductibles and co-pays), also on a sliding scale based on income. This is how it will work:

For individuals and families at 100-to-150 percent of the federal poverty level, plans must absorb 94 percent of the total cost of the plan, leaving beneficiaries to pay the remaining 6 percent. As personal income rises, the amount that individuals or families must contribute to the plan's total costs will increase. For example, beneficiaries who are at 250-to-400 percent of the federal poverty level must cover 30 percent of the total allowed costs of benefits, with insurance plans covering 70 percent. Admittedly, this amount could be steep for many families if they wind up with expensive medical bills. These cost-sharing percentages are eased, however, by specific out-of-pocket limits imposed on the plans in the new insurance exchanges. The plans in the exchanges will have caps imposed on them on the amount of the out-of-pocket costs they may pass along to the consumer. These limits are set at the maximum amounts allowed for health savings accounts, which currently are $5,950 for individuals and $11,900 for families. This means that individuals and families could be required to share, through deductibles and co-pays, in a certain percentage of the plans costs, up to the ceiling amount set by health savings account limits. In addition, in the small group market, the deductibles are capped even lower, at $2,000 for individuals and $4,000 for families. Even these amounts could be fiscally challenging for many households. The House version of health reform better addressed cost-sharing with greater subsidies; they, however, were not included in the legislation that was passed.

Impact on Small Business

Employers who fail to offer qualified health insurance to their employees will be required to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers (fewer than 50 employees).

Starting this year, small business employers (fewer than 25 employees) are eligible for tax credits to purchase insurance for their employees. For 2010-2013, a tax credit up to 35 percent of the cost of premiums is available, conditional upon the employer paying at least half of the premium. Starting in 2014, small businesses that purchase coverage through the insurance exchange will be provided a tax credit of 50 percent of the cost of

the employer contribution (conditional upon employer paying at least 50 percent of the full cost of the premium).

Insurance Exchanges

Starting in 2014, all states will be required to have in operation state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, through which individuals and small businesses with fewer than 100 employees can purchase qualified coverage. States may chose to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional exchanges or allow more than one exchange to operate in a state as long as each exchange serves a distinct geographic area. The federal government will provide grants to states to create the exchanges.

The U.S. Office of Personnel Management will be required to contract with insurers to provide at least two multi-state insurance plans in each exchange, with one plan being non-profit. This will provide an opportunity for insurance plans to operate across state lines. Consumer operated and oriented plans (CO-OPs) will be made available in all 50 states, with $6 billion provided to finance the creation of cooperatives. The Co-Ops are in lieu of a public option, which was only included in the House version of health reform and not part of the final bill that was signed by the President.

Each exchange will establish four different levels of benefits, plus a catastrophic plan. The U.S. Department of Health and Human Services will establish an essential health benefits package that provides a comprehensive set of services and covers at least 60 percent of the actuarial value of covered benefits. All plans in the exchanges must provide the essential benefits package as determined by HHS. The benefits package will be updated annually. While all plans in the exchange must provide the essential benefits package, each exchange will create the following categories of plans:

- **Bronze plan** provides the essential benefits coverage with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
- **Silver plan** covers 70 percent of the benefit costs of the plan, with the HSA out-of-pocket limits;
- **Gold plan** covers 80 percent of the benefit costs of the plan, with the HSA out-of-pocket limits;
- **Platinum plan** covers 90 percent of the benefit costs of the plan, with the HSA out-of-pocket limits;
- **Catastrophic plan** is available to those up to age 30 or to those who are exempt from the mandate to purchase coverage. This plan will only be available in the individual market.

Starting in 2014, states are permitted to create a Basic Health Plan for uninsured individuals with incomes between 133 percent and 200 percent of the federal poverty level in lieu of these individuals receiving premium subsidies to purchase coverage in the exchanges.

Health Insurance Regulation

HHS is charged with immediately establishment of a process to review increases in premiums for health insurance coverage, and to require plans to justify increases, with states providing HHS information on trends in premium increases and recommendations for any insurer to be denied access to exchanges based on rate increases. HHS will create an Internet portal for individuals or small businesses in any state to identify health insurance coverage options, including insurance, Medicaid, Medicare or high-risk pools

Starting in six months, plans will be prohibited from placing lifetime limits on the dollar value of coverage. They will not be allowed rescind coverage except in cases of fraud, and be prohibited from having pre-existing condition exclusions for children. Starting in 2014, plans cannot have annual dollar value caps on coverage and plans cannot have pre-existing condition clauses for adults.

Starting in 2011, health insurance plans in the individual and small group markets must spend 80 percent of their premiums on medical care, and in large group markets 85 percent of premiums on medical care. Plans that fail to meet these thresholds must rebate the difference to their policyholders. This provision is intended to cap industry profits over health services.

Starting in 2014, insurers will be prohibited from denying coverage or setting rates based on health status, medical condition, claims experience, genetic information, evidence of domestic violence or other health-related factors. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age.

Starting in 2014, deductibles in the small group market will be capped at $2,000 for individuals and $4,000 for families. Waiting periods for insurance coverage will be capped at 90 days, and all new policies (including those outside of the exchange) will be required to comply with one of the four benefit categories. Existing employer-based plans are grandfathered and excluded from having to meet these requirements.

Medicaid Expansion and HIV Coverage

Starting in 2014, Medicaid will be expanded to all low-income individuals, including those who are HIV-positive, whose income is below 133 percent of the federal poverty level. The federal government will pay 100 percent of the cost of expansion for 2014-2016, then phase down to a 90 percent federal match in 2020 and beyond. In a key win for states such as New York, the approved reconciliation bill provides that states that have already expanded eligibility to adults with incomes up to 100 percent of the federal poverty level will receive a phased-in increase in the federal medical assistance percentage (FMAP) so that by 2019 they will receive the same federal financing as all states.

The expansion of Medicaid to all low-income individuals is a major, critical win for the HIV community. It will mean comprehensive health care coverage, beginning in 2014, for thousands of persons living with HIV in many states who currently are on ADAP, which has limited coverage, or are struggling with few options to pay for HIV primary medical care. For the first time, eligibility for state Medicaid programs will not be connected to an AIDS diagnosis – merely income levels will determine eligibility.

Medicaid payments for fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) will be raised to match the Medicare payment rates by 2014. The federal government will pay 100 percent of the cost of the increase in Medicaid reimbursement to match Medicare rates. This may prove very important to improving access to health care providers for Medicaid beneficiaries in states with extremely low Medicaid reimbursement.

Medicare

In order to help Medicare beneficiaries with the Part D coverage gap, otherwise known as the donut hole, a $250 check will be sent to all Medicare Part D enrollees this year. Starting in 2011, Part D enrollees who hit the donut hole will receive a 50 percent discount on the total cost of their name brand drugs. In addition, starting in 2013, Medicare subsidies for the coverage gap will gradually increase so that by 2020, three-quarters of the gap will be reduced.

Overpayments to Medicare Advantage Plans will be reduced to the level of Medicare fee-for-service rates over the next three years, with the savings from this going to help pay for the cost of the health care expansion. The annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, will be reduced, along with an adjustment for productivity. For providers who rely on Medicare reimbursement, it will mean that over time the normal increases they receive will be lowered.

The law creates an independent, 15-member Medicare Advisory Board that is charged with providing Congress with proposals to reduce costs and improve quality for Medicare beneficiaries. When Medicare costs are projected to exceed certain targets, the Advisory Board's proposals will automatically take effect unless Congress passes an alternative measure to achieve the same level of savings. The Board is prohibited from making proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility or cost-sharing standards.

Prevention Efforts

A national Prevention, Health Promotion and Public Health Council will be created to coordinate federal prevention, wellness and public health activities, and a national strategy will be developed to improve the nation's health. A grant program will be established to support the delivery of evi-

dence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities.

In both Medicare and Medicaid, cost sharing will be gradually eliminated for proven preventative services as recommended by a Preventive Services Task Force. Especially for Medicare beneficiaries, it will mean that visits to the doctor for preventative services will not include co-pays.

Long-Term Care

The late Sen. Edward M. Kennedy's Community Living and Assistance Supportive Services (CLASS) Act was included in the final legislation. It was part of the Senate version of health reform, and creates a voluntary long-term care insurance program, which helps individuals to pay for non-medical services and supports, such as home personal care services. The program will be financed through automatic payroll deductions. While voluntary, individuals will have to opt-out so as not to get coverage.

States will now have the option for offering home and community-based services through a Medicaid state plan rather than through a waiver. This will mean that states may begin to expand Medicaid coverage to include home care services, should they wish. Home care has proven to be a less expensive alternative to nursing home care for many patients, yet many states currently do not have home care services paid for through Medicaid. The only option for patients in many states is to go directly into a nursing home once they are unable to care for themselves alone, which is far more expensive and highly disruptive to patients.

Other Reform Provisions

The legislation significantly increases the federal government's investment in community health centers, with a goal of doubling the number of community clinics over the next five years. The law also provides new investment in training programs and modifications to the federal student loan program to increase the number of primary care doctors, nurses and public health professionals, including loan repayment/forgiveness for those who provide services in underserved areas.

In a number of areas throughout the bill, pilot projects and experiments will be conducted in new billing methods, pay for performance, bonus payments for care coordination and medical home models of care, among others.

No "Single Payer" Strategy

For some advocates of reform, the most ideal and meaningful reform would have been better accomplished if the U.S. had abandoned the private market health insurance system and instead switched to a single payer system such as in Canada or the United Kingdom. A great portion of health insurance costs are wasted on the huge administrative burdens imposed on the economy with multiple payers, confusing and conflicting rules among companies, and overhead and profits absorbed by insurance companies. Considering that the current version of health reform barely passed the House (219-212), such a drastic change was unrealistic. And leery Democratic Senators, such as Blanche Lincoln, would have most likely not supported reform if it moved the United States into a single-payer model. In addition, some countries such as the Netherlands formerly had such a system, found it unpopular and chose to switch to a private market system with an individual mandate.

Overall, while this law may not be perfect, it is a tremendous step forward to ensuring universal access to health care for U.S. citizens.

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