



CRS Issue Statement on Health Care Reform

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On March 23, 2010, President Obama signed health reform legislation into law—the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), some provisions of which were amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Regarding private health insurance, PPACA will be fully implemented in 2014, when most individuals, large employers, and health plans are to meet certain coverage requirements. PPACA will restructure the private health insurance market, particularly for individuals purchasing coverage on their own (who may qualify for premium credits) and small businesses, partly by supporting states' creation of "American Health Benefit Exchanges" through which eligible individuals and small businesses can access private insurers' plans. Private health insurance provisions that take effect prior to 2014 (including some this year) include the following: ending lifetime and unreasonable annual limits on benefits, prohibiting rescissions of health insurance policies, requiring coverage of preventive services and immunizations, extending dependant coverage up to age 26, capping insurance companies' non-medical administrative expenditures, guaranteeing coverage for preexisting health conditions for enrollees under age 19, and providing assistance for those who are uninsured because of a preexisting condition.

PPACA raises revenues to pay for expanded health insurance coverage by imposing excise taxes and fees on industries in the health care sector, limiting tax-advantaged health accounts, and increasing the Medicare payroll tax on upper-income households and adding an additional tax on net investment income on upper-income households. The new laws will also eliminate the deduction for expenses allocable to the Medicare Part D subsidy.

PPACA makes numerous changes to the Medicare program that will impact provider reimbursements, provide incentives to increase the quality and efficiency of care, and enhance certain Medicare benefits. For instance, major savings are expected from constraining Medicare's annual payment increases for certain providers, basing payment rates in the Medicare Advantage program on average bids, reducing payments to hospitals that serve a large number of low-income patients, and creating an independent Medicare Advisory Board to make changes in Medicare payment rates. Other provisions in PPACA address more systemic issues such as increasing the efficiency and quality of Medicare services, and strengthening program integrity. For example, PPACA requires the establishment of a national, voluntary pilot program that bundles payments for physician, hospital and post-acute care services with the goal of improving patient care and reducing spending. Another provision adjusts payments to hospitals for readmissions related to certain potentially preventable conditions. Additionally, PPACA increases funding for anti-fraud activities, and subjects providers and suppliers to enhanced screening before allowing them to participate in the Medicare program. PPACA also improves some benefits provided to Medicare beneficiaries. For instance, Medicare prescription drug program enrollees will receive a 50% discount off the price of brand name drugs during the coverage gap (the "doughnut hole") starting in 2011, and the coverage gap will be phased out by 2020. Other provisions expand assistance for some low-income beneficiaries enrolled in the Medicare drug program, and eliminate beneficiary copayments for certain preventive care services.

Beginning in 2014, or sooner at state option, nonelderly, non-pregnant individuals with income below 133% of the federal poverty level (FPL) will be newly eligible for Medicaid. From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of these newly eligible individuals, with the percentage dropping to 90% (with states covering the difference) by 2020. This change represents the most significant expansion of Medicaid eligibility in many years. In addition, the health reform law adds new mandatory benefits to Medicaid, including, for example,

coverage of services in free standing birthing centers and tobacco cessation services for pregnant women. The new law also expands state options for providing home and community-based services as an alternative to institutional care and provides financial incentives to states to do so. Among the Medicaid financing changes, the health reform law reduces Medicaid disproportionate share hospital (DSH) allotments, increases certain pharmacy reimbursements, increases primary care physician payment rates for selected preventive services, and increases federal spending for the territories.

The new law maintains the current structure of the State Children's Health Insurance Program (CHIP) and extends federal appropriations for two years, through FY2015. States will receive higher federal matching rates for CHIP services beginning in FY2016 (if federal CHIP funds are available). States are required to maintain CHIP eligibility levels through FY2019 as a condition of receiving federal matching funds for Medicaid expenditures (notwithstanding the lack of corresponding federal CHIP appropriations for FY2016 and beyond), with some exceptions. Beginning in 2016, in the absence of additional federal allotments, CHIP children will obtain coverage under Medicaid (if eligible) or in qualified health plans (with coverage and cost-sharing protections comparable to CHIP currently) through the state-based exchanges.

PPACA includes numerous provisions intended to increase the primary care and public health workforce, promote preventive services, and strengthen quality measurement, among other things. It amends and expands many of the existing health workforce programs authorized under Title VII (health professions) and Title VIII (nursing) of the Public Health Service Act (PHSA); creates a Public Health Services Track to train health care professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response; and makes a number of changes to the Medicare graduate medical education (GME) payments to teaching hospitals, in part to encourage the training of more primary care physicians. The new law also establishes a national commission to study projected health workforce needs.

In addition, PPACA creates an interagency council to promote healthy policies and prepare a national prevention and health promotion strategy. It establishes a Prevention and Public Health Fund to boost funding for prevention and public health, increases access to clinical preventive services under Medicare and Medicaid, promotes healthier communities, and funds research on optimizing the delivery of public health services. Funding also is provided for maternal and child health services, including abstinence education and a new home visitation program. PPACA also establishes a national strategy for quality improvement, creates an interagency working group to advance quality efforts at the national level, develops a comprehensive repertoire of quality measures, and formalizes processes for quality measure selection, endorsement, data collection and public reporting of quality information. It creates and funds a new private, nonprofit comparative effectiveness research institute.

Other key provisions in PPACA include programs to prevent elder abuse, neglect, and exploitation; a new regulatory pathway for licensing biological drugs shown to be biosimilar or interchangeable with a licensed biologic; new nutrition labeling requirements for chain restaurant menus and vending machines; new requirements for the collection and reporting of health data by race, ethnicity, and primary language to detect and monitor trends in health disparities; and electronic format and data standards to improve the efficiency of administrative and financial transactions between health care providers and health plans.

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