WHAT IS THE ACA AKA OBAMACARE?

The actual name of the ACA (also known as Obamacare) is the Patient Care and Affordable Care Act of 2010.

The provisions in this law were implemented over a four year period (2010-2014).

We’ll go over some terminology you need to know as well as key features of the plan year by year. We’ll also take a look at what the insurance landscape looks like now in two states.
The benefits of the Affordable Care Act.
INSURANCE TERMINOLOGY YOU NEED TO UNDERSTAND

- **Network**: facilities, providers, and suppliers a health insurance company contracts with to provide health care services.

- **Deductible**: amount owed for health care services before health insurance covers before it begins to pay. For example, if you have a $1,000 deductible, your health insurance plan will not pay any costs until the deductible is met. If you need stitches and the bill is $450, you are responsible for that $450 and still have $550 left before your deductible is met and your plan begins to pay some of the costs.

- **Co-insurance**: your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

- **Copay/Copayment**: an amount you may be required to pay as your share of the cost for a medical service or supply. A copayment is usually a set amount rather than a percentage. For example, when you go see your doctor because you are sick, you are charged a copay that day (usually between $0 - $50).

- **A Premium**: the amount that must be paid for your health insurance plan. An individual and/or the employer usually pay it monthly, quarterly, or yearly. This does not include your deductible, copay, or co-insurance and if you do not pay your premium, you could lose your coverage.

- **Out-of-pocket (OOP) maximum**: a set amount that is the most that you pay during a policy period (usually one year) before your health insurance starts to pay for 100% of covered benefits. The OOP limit includes deductibles, co-insurance, and copays, or other expenditures required of an individual for a qualified medical expense. However, this does NOT include your premium or spending for non-essential health benefits.

- **Explanation of Benefits (EOB)**: a summary of charges (not a bill) that your health insurance plan sends you after you see a provider or get a service. It is a record of the health care provided to individuals covered on a policy and how much the provider is charging for those services on that plan and how much was covered by the insurance. Any unpaid amounts will be sent in a bill by the provider.
2010 — THE YEAR IT ALL BEGAN

In 2010, a Patient’s Bill of Rights goes into effect offering:

Consumer Protections (what most folks know about)
Quality and Cost Provisions
And
Increasing Access to Affordable Care

2010 was by far the biggest year in terms of changes until the individual mandate when into place in 2014.
2010: CONSUMER PROTECTIONS

- Insurance companies must put information online so that consumers may better compare coverage options to pick the best one for their needs.

- The denial of coverage of children (under 19) based on pre-existing conditions is prohibited.

- It becomes illegal for insurance companies to rescind coverage (for an error or technical mistake often unrelated to actual illness to deny payment for services when a consumer becomes ill.)

- Annual and lifetime limits on Insurance Coverage are eliminated. Before the health care law, many health plans set an annual and/or lifetime limit — a dollar limit on their yearly spending for your covered benefits. You were required to pay the cost of all care exceeding those limits.

- The law provides a way for consumers to appeal coverage determinations or claims with the insurance company and establishes an external review process.

- Consumer assistance programs are established. States that apply receive federal grants to help set up or expand independent offices to help consumers navigate the private health insurance system.
2010: QUALITY AND COST PROVISIONS

**Small Business Tax Credits**: The 1st phase provides a credit worth up to 35% of employer’s contribution to employee’s health insurance; small non-profit organizations may receive up to a 25% credit.

**Free Preventative Care**: All plans must cover preventative services without charging a co-pay or coinsurance, and without charging a deductible. (Includes colonoscopies, mammograms, contraception, STD screenings, yearly physical exams, yearly well-woman visits, well-child visits, immunizations, etc)

**Cracking down** on Health Care Fraud
Prior to the ACA taking full affect in 2014, the Patient Care Act provided access to insurance (not at low cost) to individuals unable to access insurance for at least 6-months because of a pre-existing condition.

Young Adults could stay on parents’ plan until age 26, regardless of attendance at school.

New incentives were added in the law to expand the number of primary care doctors, nurses, and physician assistants, including scholarships and loan repayments for primary care providers in working in underserved areas.

Insurance companies are held accountable for “unreasonable” rate hikes. Under this, health insurers must justify rate increases of 10% or more.

States could cover more people through Medicaid; this is the federal matching funds for low-income individuals and the new federal funds for some individuals who were not previously eligible. The Federal Government will cover 100% of new costs associated with the Medicaid expansion through 2016 and 90% of the new costs indefinitely. In the past, states were either required to meet the provision or lose all the money allocated towards a project (for example, increasing the drinking age to 21 or losing all federal funds for highways). This provision was made optional for states by the Supreme Court; states could still keep their old Medicaid dollars without enacting the new provision/taking the new dollars. Some states have opted in and others have opted out (more on this in a bit).

Increasing payments for Rural Health Care providers

Strengthening and opening new Community Health Centers
For Seniors on Medicare, the new changes provide free preventative care, including wellness visits and personalized prevention plans. The Community Care Transitions Program was started to help high risk Medicare beneficiaries when they leave the hospital.

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.

A provision take effect that requires 85% of all premium dollars collected by insurance companies from large employer plans, and at least 80% of premiums of plans sold to individuals and small businesses, be spent on health care services and health care quality improvement.
The law allows the linking of payment to quality outcomes by establishing a hospital Value-Based Purchasing program in Medicare. The program offers financial incentives to hospitals to improve the quality of care; hospital performance is required to be publicly reported. This includes “bundling” so that a hospital may bundle services with providers for a flat fee per service type (i.e. surgery).

Electronic Health Records – the plan requires that the health care industry begin to adopt and implement rules for the secure, confidential, electronic exchange of health information. The health care industry was one of the last to work with primarily paper files; this portion of the law requires that hospitals, offices, and health systems to move toward Electronic Health Records.
New funding made available to state Medicaid programs that chose the Medicaid expansion to cover preventative services for patients.

Bundle payments by Medicare become available to hospitals/doctors/providers. Under this pilot program, hospitals/doctors/providers work together to improve the coordination and quality of patient care. By bundling these payments together as one charge to Medicare rather than individual charges for each service or test, hospitals/doctors/providers are paid a flat fee for “an episode of care”. 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.

Increasing Medicaid payments to primary care doctors by requiring 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.
Insurance companies can no longer refuse to sell coverage or renew policies to individuals because of pre-existing conditions. On the individual/small group market, insurance companies may no longer charge higher rates due to gender or health status.

Insurance companies will no longer be able to drop or limit coverage for individuals who choose to participate in clinical trials. This applies to all clinical trials that treat cancer or other life-threatening diseases.

Tax credits are available for people with incomes between 100% and 400% of the poverty line who are not eligible for other affordable coverage. The tax credit is advanceable, so it can lower premium payments each month, rather than having to wait for a refund.

The Health Insurance Marketplace is established. If an employer does not offer insurance, individuals can buy it directly from the Marketplace. Small business may also partake in this Marketplace. As of 2014, Members of Congress are required to purchase insurance through the Marketplace.

The small business tax credit is increased (stage two); a credit of up to 50% of the employer’s contribution to health insurance for employees; small non-profits can receive a credit of up to 35%.

Increased access to Medicaid (for those states who chose to implement the changes). Individuals who earn less than 133% of the poverty level are eligible to enroll in Medicaid.

The Individual Mandate is instituted; those who can afford basic health care coverage will be required to obtain it or pay a fee to help offset the costs of caring for the uninsured. If affordable health care is not available, individuals will be eligible for an exemption.
TAX CREDITS FOR INDIVIDUALS & ACCESS TO MEDICAID

Want to see this whole comic that gives a concise (if not always non-political) take on key provisions of the Affordable Care Act? Check it out here.
THE CARROT AND THE STICK

How to make this work for everyone.
CARROT VS STICK

Carrot
- Tax credits
- Coverage regardless of pre-existing condition
- Health care more affordable/free preventative services
- Insurance

Stick
- The Individual Mandate: Purchase insurance or pay a fee at tax time
WHAT DOES IT ALL MEAN?

Nationally almost 11.7 million individuals are enrolled in health insurance through the Marketplace.

About **16.4 million** people have gained health insurance coverage since the expansion of the Affordable Care Act.

According to **Gallup**, the uninsured rate in the 1st quarter of 2015 is about 11.9% nationally, compared to 18% in 2013.
STATE BY STATE
What does this look like on the ground?
ARIZONA: HAS EXPANDED MEDICARE COVERAGE

➢ 205,666 Arizonans were enrolled in coverage through the Marketplace (outside of employer plans) as of Feb 22.

➢ 75% of Arizona consumers qualified for an average tax credit of $155/month through the Marketplace.

➢ 52% of Arizona Marketplace enrollees gained health insurance for $100 or less after applicable tax credits in 2015 and 86% had the option of doing so.

➢ There were 10 health issuers in Arizona in 2014; 13 in 2015

➢ In 2015, Arizonans could select from an average of 71 different health plans (from those 13 providers).

➢ 68% of plans in the Marketplace were purchased by individuals between the ages of 18 – 35.

➢ According to Gallup, the uninsured rate in Arizona was 17.5% in 2014 compared to 20.4% in 2013. (In Massachusetts, where this whole idea originated with Mitt Romney, the uninsured rate in 2014 was 4.6% down from 4.9% in 2013).
TEXAS: HAS NOT EXPANDED MEDICARE COVERAGE

- 1.2 million Texans were enrolled in coverage through the Marketplace (outside of employer plans) as of Feb 22.

- 85% of Texas consumers qualified for an average tax credit of $239/month through the Marketplace.

- 68% of Texas Marketplace enrollees gained health insurance for $100 or less after applicable tax credits in 2015 and 92% had the option of doing so.

- There were 12 health issuers in Texas in 2014; 15 in 2015

- In 2015, Texans could select from an average of 31 different health plans (from those 15 providers).

- 68% of plans in the Marketplace were purchased by individuals between the ages of 18 – 35.

- According to Gallup, the uninsured rate in Texas was 24.4% in 2014 compared to 27% in 2013.
  (In Massachusetts, where this whole idea originated with Mitt Romney, the uninsured rate in 2014 was 4.6% down from 4.9% in 2013).
WHAT NEXT?

Talk with your parents about what their/your insurance plan entails. What are the deductibles, copays, coinsurance, premiums?

Do your own research on the Patient Care and Affordable Care Act. Determine one thing you think is a “pro” and one thing you think is a “con”; understand the arguments for/against them.
WEBSITES USED IN THIS OVERVIEW

The Comic Overview of the ACA is here: http://boingboing.net/2014/10/29/obamacare-what-it-is-what-it.html
HHS basics: http://www.hhs.gov/healthcare/rights/
HHS Key Features infographic: http://www.hhs.gov/healthcare/facts/timeline/index.html
HHS Key Features year by year timeline: http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html
State By State Comparisons: http://www.hhs.gov/healthcare/facts/bystate/statebystate.html

Other sites:
http://www.hhs.gov/healthcare/rights/sbc/index.html
http://obamacarefacts.com/sign-ups/obamacare-enrollment-numbers/
http://www.stopmedicarefraud.gov/
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