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Primer: The Patient Protection and Affordable Care Act

Sarah Schmidt | September 22, 2011

Introduction

Since the beginning of the 20th century, presidents and Congress have attempted to reform the U.S. healthcare system. In 2008, 46 million Americans lacked health insurance coverage and much of the presidential race focused on ways to change the state of health care coverage for Americans. Early in his presidency, President Obama established the Office of Health Reform and healthcare reform efforts dominated the administration's domestic agenda.

In November 2009, the House passed the "Affordable Health Care for America Act". Within a few weeks, the Senate passed a similar bill, entitled "The Patient Protection and Affordable Care Act". While both bills aimed to improve healthcare coverage, there were discrepancies in the financing mechanisms for the reforms, public plan options and level of government subsidies. In response, the White House released President Obama's proposal for healthcare reform, which attempted to reconcile both Congressional bills. After much debate, the House passed the Senate's version of the bill, and the President signed the "Patient Protection and Affordable Care Act" (P.L. 111-148) on March 23, 2010. See the Appendix for an implementation timeline highlighting the main reforms of the PPACA.

Current State of Healthcare in the U.S.

- Health spending in the United States averaged \$8,086 per person in 2009, totaling \$2.5 trillion, or 17.6 percent of our nation's economy, up from 7.2 percent of GDP in 1970 and 12.5 percent of GDP in 1990ⁱ.
- Medicare accounts for 14 percent of the total federal budget, more than the 7 percent accounted for by Medicaid, but a smaller share than Social Security (22 percent) or defense (20 percent)ⁱⁱ.
- Only 39 percent of the Americans have a favorable view of the Health Reform Lawⁱⁱⁱ.
- 53 percent of Americans disapprove of the way the Obama administration is handling healthcare reform^{iv}.
- Federal spending on Medicare and Medicaid has increased from 1.3 percent of GDP in 1975 to 5.5 percent of GDP in 2010 (Figure 1).

For more information, please contact the American Action Forum's Director of Healthcare Policy, Michael Ramlet, at mramlet@americanactionforum.org.

Key Takeaways

Questionable Mandate for Insurance Coverage

- Under the PPACA, U.S. citizens and legal residents will be required to have qualifying health coverage or face a tax penalty.
- The constitutionality of this mandate is being brought under scrutiny by courts.

Greater Enrollment in Already-Stressed Medicaid

- The struggling Medicaid program will be expanded to cover an additional 25 million people by 2020.

Unsustainable Health Spending

- Overall national health expenditures under the PPACA would increase by an estimated \$222 billion between 2010 and 2019.

Tax Penalties Imposed on Employers

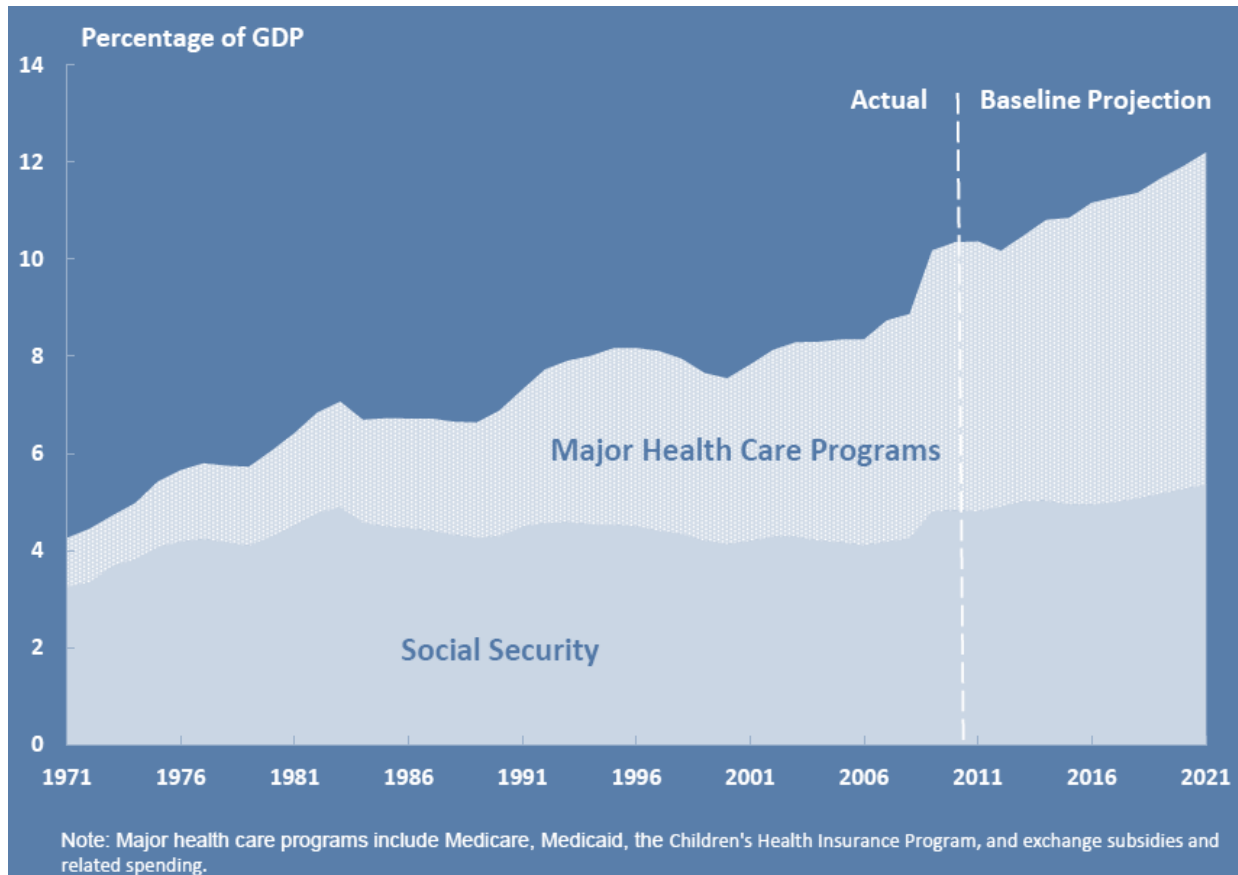
- Employers with more than 50 employees will be required to provide health insurance coverage for employees or face an annual tax penalty.

States Required to Establish Insurance Exchanges

- Each state is mandated to establish a health insurance exchange by 2013 or the government will step in and implement compulsory federal exchanges.

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Figure 1: Federal Spending on Medicare and Medicaid^v



Changes to Medicare and Medicaid

Medicare and Medicaid are the U.S. healthcare system's largest public programs. The Kaiser Family Foundation estimates that in 2011, over one hundred million low-income, disabled, and elderly beneficiaries have been or will be served by the two programs. The number of beneficiaries and the extent of their healthcare needs have burdened the public system and made reform necessary. The PPACA attempts to restructure certain aspects of the public entitlement programs, as well as expand coverage to a larger population. Medicaid will be expanded to all non-Medicare eligible individuals under age 65 who earn an income up to 133 percent of the federal poverty level.

In 2010, Medicare accounted for 15 percent of the federal budget^{vi}. The combination of rising health costs, an expanded Medicaid population, and a rapidly aging population, prompts the necessity of cost-saving measures in coordination with the PPACA. The law attempts to address rising costs by increasing the Medicare payroll tax rate by 0.9% for high-income individuals and families, and reducing Medicare reimbursement in cases of readmission, hospital-acquired infections and disproportionate share hospital payments.

The PPACA also restructures payments to Medicare Advantage plans by setting percentage fee-for-service rates and allowing Accountable Care Organizations (ACOs) to share in cost savings from Medicare. In a long-term effort to control the growth of Medicare costs, PPACA authorized the creation of an Independent Payment Advisory Board (IPAB). IPAB will consist of non-elected members who will have the power to issue recommendations on

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methods of cost-reduction for Medicare, which will then be fast-tracked for Congressional consideration and implementation. Finally, the PPACA allows for drug rebates to Medicare beneficiaries who reach the Part D coverage gap in 2010 (often referred to as the “donut hole”) and will attempt to further minimize the Medicare drug coverage gap by providing increasing drug discounts and federal subsidies^{vii}.

Government Mandates to Individuals

A key stipulation to the implementation of PPACA is the mandate for all U.S. citizens and legal residents to have health insurance. Persons who do not have “qualified” health coverage, as determined by the government, will be required to pay a tax penalty of the greater of \$695 per years or 2.5 percent of household income^{viii}. The tax penalty will increase annually, in accordance with the cost-of-living adjustment. Some exemptions will be granted for religious objections, American Indians, undocumented immigrants, incarcerated individuals, and financial hardship.

New Employer Requirements

The health care law does not directly mandate an employer to provide health insurance to employees, but imposes tax penalties on certain employers who do not offer coverage. Companies that have 50 or more workers must pay an annual tax penalty of \$3,000 per worker if at least one worker qualifies for and accepts a health insurance premium subsidy from the federal government and is insured through the exchanges. Additionally, companies with more than 50 workers that do not offer a “qualified” health plan or pay at least 60 percent of workers’ health insurance premiums face an annual tax penalty of \$2,000 per worker^{ix}.

New Fees and More Federal Spending

The health care law increases federal outlays and perpetuates the federal government’s upward trend of unsustainable spending. If the U.S. continues the current spending levels, The Congressional Budget Office (CBO) estimates the public debt to more than double from its 2008 level to 90% of GDP^x. In an attempt to reduce the increasing federal deficit exacerbated by PPACA, the health care law mandates an increase in the collection tax revenue. The law assesses new annual fees on the pharmaceutical sector, an excise tax on the sale of medical device manufacturers and increasing annual fees on health insurance providers. An increase in federal tax revenues will raise additional revenue to compensate for the increase in outlays temporarily, but the long-term effects of unsustainable spending and increasing taxes will undercut the economic growth for a U.S. economy still recovering from economic recession.

Issues Currently Under Debate

How will state health insurance exchanges work?

A key component by which the PPACA expands insurance coverage access to individuals across the U.S. is through the implementation of state-based health insurance exchanges. These exchanges are scheduled to begin operating by January 2014, and are intended to provide a variety of health insurance options to consumers who either do not have employer-based coverage or receive subsidies to purchase health insurance through the exchanges. The goal of the exchanges is to give states more control over health insurance options for their residents. However, if a state fails to organize an exchange by January 1, 2013, the Department of Health and Human Services will intervene and implement a federally designed and controlled exchange. Over the next ten years, the exchanges are estimated to

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cost over \$783 billion in federal dollars^{xi}.

How will states react to the PPACA?

As of July 2011, 15 states had begun to establish exchanges. However, continued uncertainty about the constitutionality of PPACA and disagreements within state governments about the policies within the PPACA has led many states to neglect to establish and implement exchanges.

Is the PPACA constitutional?

As of September 21, 2011, twenty-seven federal lawsuits have been filed seeking to overturn the PPACA. Of these lawsuits, Florida, Pennsylvania, Virginia, and the 11th Circuit courts have overturned parts of or the entire law. The health care law challenges an individual's freedom to make the choice to purchase health insurance and further extends government regulation within healthcare, insurance markets, and interstate commerce. Due to split decisions between the 11th Circuit Court and 6th Circuit Court, the case will most likely appear before the U.S. Supreme Court for a final decision prior to the end of its term in June 2012.

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Appendix: PPACA Implementation Timeline^{xii}

2010

- Federal Coordinated Health Care Office established to coordinate dual eligibles.
- FDA can grant biologics manufacturers 12 years of exclusive drug use prior to generic development.
- Require non-profit hospitals to conduct community needs assessments.
- Medicaid coverage available to childless adults with income up to 133% of poverty level.
- Temporary reinsurance program established for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
- Temporary program to provide health insurance to individuals with pre-existing conditions who have been uninsured for at least six months.
- 10% tax on indoor tanning services
- Insurance coverage extended for adult dependent children up to age 26.
- Insurance plans prohibited from placing lifetime limits on coverage, denying children based on pre-existing conditions, and from rescinding coverage (except in fraud).
- Require health plans to provide minimum preventive services.

2011

- Eliminate cost-sharing for Medicare-covered preventive services.
- Require disclosure of nutritional content of standard menu items at chain restaurants and vending machines.
- Begin funding Medicare Independent Payment Advisory Board (IPAB).

2012

- Reauthorize annual fees on the pharmaceutical manufacturing sector.
- Reduce Medicare payments to hospitals by specified percentages for excess preventable hospital readmissions.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.

2013

- Limit contributions to a flexible spending account for medical expenses to \$2,500 per year.
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% adjusted gross income to 10% adjusted gross income.
- Eliminate tax deductions for employers who receive Medicare Part D retiree drug subsidy payments.
- Increase Medicare Part A tax rate on wages by .9% for earnings over \$200,000 for individuals and \$250,000 for married couples filing jointly.
- Impose 3.8% tax on unearned income for higher-income taxpayers.

2014

- Assess fees on employers with greater than 50 full-time employees who do not offer medical coverage.
- Require U.S. citizens and legal residents who do not have qualifying health coverage to pay a tax penalty, which will increase annually.
- Expand Medicaid to all non-Medicare eligible individuals under 65 with income up to 133% of the federal poverty level.
- Increase Medicaid payments for fee-for-service and managed care to primary care services provided by primary care doctors.
- Provide credits to eligible individuals and families with income between 133-400% FPL to purchase insurance through the Exchanges.
- Impose increasing annual fees on the health insurance sector.

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Operation Healthcare Choice is the Forum's public policy center focused on promoting high-value healthcare and higher quality health insurance that expands consumer choice. Operation Healthcare Choice experts conduct research, offer commentary, and develop policies aimed at eliminating healthcare's burden on the economy.

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