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The Patient Protection and Affordable Care Act:

Implications and Opportunities for Occupational Health and Wellness Promotion

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July 14, 2011

PL 111-148 signed into law March 23, 2010

Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level.

Expand Medicaid to 133% of the federal poverty level.

Start by January 1, 2014

By six months after passage:

Dependents eligible to age 26 years

Prohibit limits for maximum lifetime benefits

Temporary high-risk pools for persons with pre-existing conditions

No exclusion of children with pre-existing conditions

Original Medicare implementing prevention benefits (Effective January 1, 2011)

Deductible waiver

**Elimination of co-payments for evidence-based
preventive services (USPSTF)**

Includes initial and annual wellness visits

Medicare Advantage

**More complicated phase in due to differing payment
structures**

Individual mandate: require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty.

Employer requirements: fees assessed for employers with 50 or more employees whose employees receive a premium tax credit.

Insurance company: guarantee issue, premium rating, prohibition of pre-existing condition exclusions

Individual within 133-400% FPL:

Premium credits – if insurance purchased through exchange based on a sliding scale

Cost-share subsidies – a percentage of cost-share covered based on sliding scale

Employer:

Tax credit to offset employer share of premium for low income employees

Create state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified insurance coverage.

Permit states to allow businesses with more than 100 employees to purchase coverage Exchange beginning in 2017.

To be fully operating by January 2014,* states must have exchanges -

being planned in 2011

being built in 2012

starting up in 2013

Otherwise, Federal government will manage the state's exchange

*** Extensions may be requested.**

Office of Personnel Management contracts with insurance companies to offer multi-state plans at least one to be run by a government or by non-profit.

Consumer operated and oriented plans (CO-OP)

State may create plan to cover 133-200% FPL without premium subsidy for purchase in exchange

Basic package to provide a comprehensive set of services, cover at least 60% of the actuarial value of the covered benefits, limit annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and be not more extensive than the typical employer plan.

All qualified health benefits plans, including those offered through the exchanges and those offered in the individual and small group markets outside the exchanges (except grandfathered individual and employer-sponsored plans) to offer at least the essential health benefits package.

Four coverage categories of plans plus a separate catastrophic plan to be offered through the exchange:

Bronze	Covers 60% of (actuarial) cost of basic benefit
Silver	70%
Gold	80%
Platinum	90%

Out-of-pocket limits that are tied to HSA deductibles'

Availability of provider system

Marketing requirements

Quality monitoring

Reporting requirements

Transparency of information

Medical loss ratio limits

Administrative simplification

Electronic data

Insurance market rules

Limits on deductible

90-day limit waiting period for enrollment

Medicare Prescription drugs

Guaranteed access

Cherry-picking blocked

Basic coverage package -

**strengthens access and coverage for mental illness,
substance use disorders, rehabilitation, long-term care**

**Builds on familiar framework (Medicaid, insurance
companies)**

Transparency

Competition

Exchanges new and complicated

Operating costs high

Cost containment efforts are largely exploratory

Service delivery system and infrastructure deficiencies

PL 11-148

Title IV: Prevention of Chronic Disease and Improving Public Health

Subtitle A: Modernizing Disease Prevention and Public Health Systems

Sec. 4001: National Prevention, Health Promotion and Public Health Council

**Also an Advisory Committee
to develop a Strategic Plan in one year**

Subtitle A: Modernizing Disease Prevention and Public Health System

National Prevention, Health Promotion and Public Health Council has been established to coordinate federal prevention, wellness, and public health activities.

Prevention and Public Health Fund has been created to expand and sustain funding for prevention and public health programs at \$5 billion for FY 2010-2014:

- Community Transformation grants

- Education and outreach campaign for preventive benefits

- Immunizations

Subtitle A: Modernizing Disease Prevention and Public Health System

Task forces on Preventive Services and Community Preventive Services are established in statute to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.

Subtitle B—Increasing Access to Clinical Preventive Services

Funds for school-based health center (facilities)

Oral health care prevention education campaign and grants

Grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011.)

TA and other resources to evaluate employer-based wellness programs.

Subtitle B—Increasing Access to Clinical Preventive Services (cont.)

Conduct a survey of worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct within two years following enactment.)

Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. (Effective January 2014.)

Establish a Workforce Advisory Committee to develop a national workforce strategy.

Increase the number of residency positions by redistributing currently unused slots, with priorities given to primary care and general surgery.

Incentives through scholarships and loans; primary care training and capacity building; state grants to providers in medically underserved areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health.

Generally beyond the scope of PPACA

**General provisions for any insurance program apply:
E.G., eligibility for dependents up to age 26**

Challenges in Federal Courts

Individual mandate

PPACA upheld in Appeals Court (Ohio, June 2011)

Eventually Supreme Court

Congressional repeal?