Law and the Public's Health

This installment of *Law and the Public's Health* provides an overview of the Patient Protection and Affordable Care Act, signed into law on March 23, 2010. The Act represents a watershed in U.S. public health policy. When fully implemented, its insurance reforms are expected to lead to coverage of 94% of the population, and its health-care provisions lay the groundwork for the fundamental transformation of the health-care system.

Sara Rosenbaum, JD
Hirsh Professor and Chair, Department of Health Policy
School of Public Health and Health Services
The George Washington University Medical Center, Washington, DC

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

Sara Rosenbaum, JD

The Patient Protection and Affordable Care Act[1] (hereinafter referred to as the Affordable Care Act), amended by the Health and Education Reconciliation Act,[2] became law on March 23, 2010. Full implementation occurs on January 1, 2014, when the individual and employer responsibility provisions take effect, state health insurance Exchanges begin to operate, the Medicaid expansions take effect, and the individual and small-employer group subsidies begin to flow. Along the way are a series of crucial intermediate steps.

A brief law column can hardly do justice to the Act and its sweep. Interested readers are encouraged to use the Obama Administration's information portal,[3] which provides multiple practical and policy tools related to implementation. Other special search-engine tools also can provide invaluable assistance in understanding the law's many dimensions and the full range of issues that will arise as implementation moves forward.[4]

OVERVIEW AND KEY ELEMENTS

The Affordable Care Act is a watershed in U.S. public health policy. Through a series of extensions of, and revisions to, the multiple laws that together comprise the federal legal framework for the U.S. health-care system, the Act establishes the basic legal protections that until now have been absent: a near-universal guarantee of access to affordable health insurance coverage, from birth through retirement. When fully implemented, the Act will cut the number of uninsured Americans by more than half. The law will result in health insurance coverage for about 94% of the American population, reducing the uninsured by 31 million people, and increasing Medicaid enrollment by 15 million beneficiaries. Approximately 24 million people are expected to remain without coverage.[5]

Consisting of 10 separate legislative Titles, the Act has several major aims. The first—and central—aim is to achieve near-universal coverage and to do so through shared responsibility among government, individuals, and employers. A second aim is to improve the fairness, quality, and affordability of health insurance coverage. A third aim is to improve health-care value, quality, and efficiency while reducing wasteful spending and making the health-care system more accountable to a diverse patient population. A fourth aim is to strengthen primary health-care access while bringing about longer-term changes in the availability of primary and preventive health care. A fifth and final aim is to make strategic investments in the public's health, through both an expansion of clinical preventive care and community investments.

Health insurance coverage reforms

Through a series of provisions that create premium and cost-sharing subsidies, establish new rules for the health insurance industry, and create a new market for health insurance purchasing, the Affordable Care Act makes health insurance coverage a legal expectation on the part of U.S. citizens and those who are legally present.[6–8] The Act both strengthens existing forms of health insurance coverage while building a new, affordable health insurance market for individuals and families who do not have affordable employer coverage or another form of "minimum essential coverage" such as Medicare or Medicaid.[9] In expanding existing coverage, the Act fundamentally restructures Medicaid to cover all citizens and legal U.S. residents with

family incomes less than 133% of the federal poverty level (as measured through a new "modified adjusted gross income" test) and to streamline enrollment.[10,11] (Medicaid's five-year waiting period for legal residents will continue to apply to recently arrived people, who during this time will qualify for tax subsidies and enrollment through a health insurance Exchange.)

The *quid pro quo* for near-universal legally guaranteed coverage is the duty to secure it, as it is not possible to extend such a guarantee of insurance coverage without an attendant coverage obligation. This duty extends to all U.S. taxpayers, but individuals not legally present in the U.S. are excluded from both the coverage guarantee and the obligation to secure coverage. The law also provides exemptions for people for whom enrollment is contrary to religious belief or remains unaffordable or a hardship.[9] But otherwise, the mandate extends to all people; indeed, it is this type of legal mandate that makes universal coverage feasible, because without it, large numbers of healthy individuals, whose presence is essential to the formation of a risk pool, would fail to enroll. Without the mandate, the private health insurance industry would not—and indeed, could not—eliminate discriminatory pricing and coverage practices, as such tactics are the means by which insurers protect themselves against adverse selection. Thus, without the mandate, universal coverage is virtually impossible, as is stabilization of the insurance foundation on which the entire health-care system rests.

In short, the Affordable Care Act represents an effort to reframe the financial relationship between Americans and the health-care system to stem the health insurance crisis that has enveloped individuals, families, communities, the health-care system, and the national economy as a whole.[9] It is also this basic reinvention of Americans' relationship to health insurance that lies at the epicenter of the legal battle over the law's constitutionality. This is because the question of whether the law falls within Congress' constitutional powers[12] rests on whether the courts come to view the legislation as regulating our economic approach to the purchase of health care (because we all use care, the issue becomes how to pay for it), or instead (as the law's opponents argue) as a law that forces individuals, as passive non-economic actors, to buy a product they do not want.[13]

In addition to establishing universal coverage and shared responsibility, the Affordable Care Act sets federal standards for health insurers offering products in both the individual and small-group markets, as well as employer-sponsored health benefit plans.[6,14] These requirements considerably expand on federal standards first introduced as part of the Health Insurance Portability and Accountability Act of 1996.[15] Some of the requirements (a prohibition against rescissions [i.e., cancellations], a ban on exclusion of children younger than 19 years of age with preexisting conditions, coverage of young adults up to 26 years of age under their parents' plans, coverage of clinical preventive benefits, expanded appeals rights when claims are denied, a ban against lifetime limits, and restrictions on annual coverage limits) become effective prior to 2014.[16] The broadest reforms—prohibitions against pricing and coverage discrimination against adults—become effective in 2014, when the mandate and subsidies go into effect.[6]

The Act's expanded insurance standards are designed to set a federal minimum; it is the expectation under the Affordable Care Act that state insurance departments will implement and enforce these laws as part of their legal insurance oversight powers. As of August 5, 2010, the National Association of Insurance Commissioners reported that half the states indicate that their insurance departments hold implementation powers, either through explicit legislation or as a result of their general powers, while nearly all states have the capacity to enforce federal standards.[17] At the same time, however, the federal government cannot force states to oversee and enforce federal laws without running afoul of the U.S. Constitution's 10th Amendment protection against the commandeering of state law enforcement resources.[18] Thus, under federal law, state implementation of federal insurance regulations remains voluntary, and the Public Health Service Act provides for direct federal regulation of state insurance markets if necessary.[19]

The Affordable Care Act sets an array of federal standards for insurers that sell products in both the individual and group health insurance markets, as well as (with certain limited exceptions not relevant to the topic of this article) for self-insured group health benefit plans sponsored by employers subject to the Employee Retirement Income Act.[6,20] The purpose of these standards, as noted, is to ban discrimination against women, older people, and children and adults in less than perfect health. Thus, the Act bans lifetime and most annual dollar coverage limitations, the use of preexisting condition exclusions, and excessive waiting periods (i.e., longer than 90 days), and requires the use of "modified community rating" so that prices can vary only to a limited degree based on age, as well as by family size and tobacco use. The law also guarantees the right to internal and external impartial appeal procedures when coverage is denied, and requires insurers to cover routine medical care as part of clinical trials involving cancer and life-threatening illnesses.

Of particular note in a public health context is the extent to which the Act regulates the content and design of coverage itself. With the exception of "grandfathered" plans (plans in effect as of March 23, 2010, which are given a transition period that lasts until they make a significant change in coverage, premiums, or cost-sharing),[21,22] insurers and employee health benefit plans will be required to cover (without cost-sharing) clinical preventive services with an "A" or "B" rating from the U.S. Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices; and other preventive services for children, adolescents, and women identified by the Health Resources and Services Administration. This requirement begins with the first plan year that occurs after September 23, 2010 (six months after the date of enactment).[14] Parallel reforms are made under Medicare[23] as well as in the case of Medicaid coverage for newly eligible adults,[11] although for "traditionally eligible" adult Medicaid beneficiaries, preventive services remain an optional benefit.[24]

The Act also encourages employers to undertake workplace wellness activities that promote and incentivize actual health outcomes. Wellness activities need not be limited to the act of participating in wellness programs but can include incentives aimed at actually achieving improved health results.[6]

Beyond subsidizing coverage and regulating the insurance and group health plan markets, the Affordable Care Act creates state health insurance Exchanges for both individuals and businesses.[25] Exchanges are meant to simplify and ease health insurance purchasing by creating a one-stop shopping market for insurance products that qualify for federal tax subsidies and that meet federal and state standards and, thus, are certified as "qualified health benefit plans." Under the Act, Exchanges are empowered to select qualified health plans, provide information and enrollment assistance, coordinate enrollment with state Medicaid programs, calculate subsidy eligibility, oversee plans, and provide information to the federal government regarding subsidy eligibility and plan performance.[26]

Qualified health benefit plans, whether sold inside or outside Exchanges, will have to meet a series of federal requirements including coverage of "essential benefits," defined under the Act to include both preventive services as well as a range of benefit classes that reflect a standard employer-sponsored plan. Qualified health plans also will be required to meet federal standards related to provider network sufficiency (including contracts with "essential community providers") and health-care quality. In addition, qualified health benefit plans will be required to make performance information conforming to national quality measurement benchmarks available to patients and consumers.[27] Qualified plans sold inside Exchanges will be required to follow certain funds segregation procedures if plan sponsors desire to offer coverage for abortions beyond those permitted under federal law (as of 2010, federally funded abortions are permitted in cases of rape, incest, and life endangerment); furthermore, states are empowered under the law to ban the sale of products covering any abortions.[28]

In advance of the 2014 effective date for the mandate, the subsidies, and the Exchanges, the Act permits states to expand Medicaid for low-income adults as a state option; states also, at their option, may extend coverage for family planning services to the low-income population.[29] The Act also creates high-risk health insurance pools (known as preexisting condition health plans) that are meant to provide affordable coverage on an interim basis for several hundred thousand people whose preexisting health conditions make coverage unavailable, uninsurable, or both.[30]

Improving health-care quality, efficiency, and accountability

Beyond insurance, the Affordable Care Act begins the job of realigning the health-care system for long-term changes in health-care quality, the organization and design of health-care practice, and health information transparency. It does so by introducing broad changes into Medicare and Medicaid that empower both the Secretary of the U.S. Department of Health and Human Services (HHS) and state Medicaid programs to test new modes of payment and service delivery, such as medical homes, clinically integrated "accountable care organizations," payments for episodes of care, and bundled payments.[31] All of these changes are intended to allow public payers to slowly but forcefully (*1*) nudge the health-care system into behaving in different ways in terms of how health professionals work in a more clinically integrated fashion, (*2*) measure the quality of their care and report on their performance, and (*3*) target for quality improvement serious and chronic health conditions that result in frequent hospital admissions and readmissions. HHS and the states are expected to test payment and delivery system reforms that also attract private payer involvement to maximize the potential for cross-payer reforms that can, in turn, exert additional pressure on health-care providers and institutions.

The Act also invests in the development of a multipayer National Quality Strategy, whose purpose is to generate multi-payer quality and efficiency measures to promote value purchasing, greater safety, and far more

extensive health information across public and private insurers.[32] In this regard, the Act ultimately will build on the Health Information Technology for Economic and Clinical Health Act, enacted into law in 2009 as part of the American Recovery and Reinvestment Act,[33] and further lays the groundwork for performance reporting on a system-wide basis so that patients can more readily get information about their own health care and how their health-care providers perform. In addition, the Act establishes the Institute for Comparative Clinical Effectiveness Research to promote the type of research essential to identifying the most appropriate and efficient means of delivering health care for diverse patient populations.[34] Throughout these initiatives to improve quality and information, the Act emphasizes efforts to collect information about health and health-care disparities to allow the nation to better assess progress not only for the population as a whole, but also for patient subpopulations who are at elevated risk for poor health outcomes.

Even as the legislation invests nearly $1 trillion over the 2010–2019 time period aimed at making coverage affordable, the Act more than offsets these expenditures through curbs on Medicare and Medicaid spending, new taxes on high-cost plans, and tax shelters used most heavily by affluent families. In addition, and of particular note to public health policy and practice, the Act significantly alters the obligations and reporting rules for nonprofit hospitals by imposing new conduct and reporting obligations on hospitals as a condition of maintaining their federal nonprofit status (a tax exemption worth more than $100 billion annually; states also provide parallel exemptions). The changes include requiring hospitals to undertake ongoing community health needs assessments; furnish emergency care in a nondiscriminatory fashion (a requirement already applicable under the Emergency Treatment and Active Labor Act; which is unaltered by the Affordable Care Act); alter their billing and collection practices; and maintain widely publicized written financial assistance policies that provide information about eligibility, how the assistance is calculated, and how to apply for assistance.[35]

Making primary health care more accessible to medically underserved populations

An estimated 60 million individuals are considered medically underserved as a result of a combination of elevated health risks and a shortage of primary health-care professionals.[36] To begin to more rapidly alleviate this shortage in advance of the implementation of the health insurance coverage requirements, the Act invests in a major expansion of community health centers and the National Health Service Corps. Over the fiscal year (FY) 2011 to FY 2015 time periods, the Act will invest $11 billion in health centers and $1.5 billion in the National Health Service Corps. Together, these expansions are expected to result in a doubling of the number of patients served, raising the total number of health center patients from 20 million in 2010 to approximately 40 million by 2015.[37]

Improving the public's health and training health professionals

In addition to insuring most Americans, making an effort to rationalize health care, investing in primary health care in medically underserved communities, and broadening coverage for effective clinical preventive health services, the Affordable Care Act makes direct public health investments. Part of these investments come in the form of new regulatory requirements related to coverage of clinical preventive services without cost sharing, a fundamental shift in the relationship between health insurance and clinical preventive care. In addition, the Act provides for the development of a national prevention plan and the establishment of a Prevention and Public Health Trust Fund to finance community investments that will improve public health.[38] The Fund, with a value set at $15 billion, provides additional funding for prevention activities beginning in FY 2010 and continuing annually.

The Act also targets specific subpopulations for new public health and health investments, particularly the area of Indian health care, which receives focused attention aimed at improving the performance of health and health-care programs.[39] New investments are made in school-based health centers, oral health-care prevention activities, tobacco cessation programs for Medicaid-enrolled pregnant women, and the addition of personalized prevention planning to Medicare.[40]

The Act also authorizes new investments in training primary care health professionals.[41] With the exception of new investments in establishing "teaching health centers," these changes are authorized but not funded as part of the Act and will need separate appropriated funding.

Long-term care

To provide for those who need long-term care, the Act creates new Medicaid options to promote community-based care and protect spouses of those with serious illness from becoming impoverished. It also creates a voluntary long-term-care insurance program, the Community Living Assistance Services and Support Act.[42]

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The Affordable Care Act will fundamentally alter the policy landscape in which public health is practiced. The legislation will take years to implement, and its full meaning can only be conceptualized at this point. But January 2014 will arrive in the blink of an eye. How do public health practitioners and policy makers seize the opportunities presented by this seminal change in policy while also working with others to rise to its challenges?

Certain aspects of the law—including the availability of prevention or health center funding—present important funding opportunities. These opportunities are vital to communities throughout the country, and public health agency responsiveness and assistance to local community coalitions will be key. At the same time, these aspects of the Act perhaps represent relatively familiar public health practice turf, from a conceptual and practical perspective.

The more intriguing questions arise from the more nuanced opportunities that arise from the new coverage and regulatory environment in which public health policy-making and practice will take place. For example, how will public health's role in prevention be affected by expanded coverage of clinical preventive services in public and private insurance? Should public health become more involved in the direct provision of certain types of clinical preventive care to assure that access is realized? How will Medicaid agencies and state Exchanges find the supply of health professionals needed to expand existing sources of care? How might public health agencies work with health professions training and residency programs in their states to begin to plan for the vast increase in demand for care? How might public health agencies work directly with employers, insurers, and health-care providers on ways to translate coverage reforms into actual improvements in health-care services?

The law requires nonprofit hospitals to engage in major community health planning; hospitals also will be expected to demonstrate how their investment of resources into the communities they serve reflects the priorities contained in their plans. How can public health agencies engage in hospitals around planning? How can agencies and communities assure optimal use of the resources that will be invested in these community planning activities and the resulting impact of plans on hospitals' community benefit expenditures?

In a similar vein, how might public health agencies relate to employers in the development of wellness programs? Programs can now contain health outcomes incentives; how can public health agencies work with employers, employees, and their families to help them actually achieve the outcomes that are incentivized, such as immunization status, weight reduction, or better management of chronic health conditions?

State Medicaid agencies, along with state health insurance Exchanges (as they come on line), will spend the next several years wrestling with the enormous challenges involved in enrolling tens of millions of people. Many will never have had insurance, many will be hard to reach, many will not have English as their primary language, and some will have limited mental capacity. What role can public health outreach play?

Health insurance Exchanges will be expected to implement broad federal standards related to access and quality for qualified health plans. Medicare and Medicaid demonstrations aimed at improving health and health care for individuals with complex and chronic conditions will be implemented. And throughout the system, large amounts of data on enrollment, health-care utilization, and performance will become available over time. What are the opportunities that flow from these changes? How might public health be involved in (*1*) outreach and enrollment, (*2*) the creation of more integrated systems of care for people with chronic conditions who depend on health-care teams drawn from both health-care and public health professionals, and (*3*) working with Exchanges to assure that the health plans that do business in Exchanges are positioned to offer quality products whose performance can be measured?

Finally, the law will leave nearly 25 million people without health insurance. What role can public health continue to play for these populations? How can effective systems of care be created to protect these individuals (and the communities in which they live) from the consequences of inadequate health-care access?

In sum, the Affordable Care Act is transformational, and enormous implementation challenges lie ahead. But the opportunities for major advances in public health policy and practice are simply unparalleled. The Act represents a singular opportunity not only to transform coverage and care, but also to rethink the basic mission of public health in a nation with universal coverage.

Sara Rosenbaum is the Hirsh Professor and Chair in the Department of Health Policy, School of Public Health and Health Services at The George Washington University Medical Center in Washington, D.C.

Address correspondence to: Sara Rosenbaum, JD, Department of Health Policy, The George Washington University School of Public Health and Health Services, 2021 K St. NW, Ste. 800, Washington, DC 20006; tel. 202-994-4141; fax 202-994-4040; e-mail <sara.rosenbaum@gwumc.edu>.

REFERENCES

1. The *Patient Protection* and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 *Stat.* 119 (March 23, 2010).
2. Health Care Education and Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010).
3. See: Department of Health and Human Services (US). HealthCare.gov [cited 2010 Sep 12]. Available from: URL: http://www.healthcare.gov
4. See, e.g.: Robert Wood Johnson Foundation, The George Washington University School of Public Health and Health Services. Health reform GPS [cited 2010 Sep 12]. Available from: URL: http://www.healthreformgps.org
5. Congressional Budget Office. Letter from Douglas W. Elmendorf, Congressional Budget Office Director, to the Honorable Harry Reid, Senate Majority Leader, March 11, 2010. Table 3 [cited 2010 Sep 12]. Available from: URL: http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf
6. PPACA §1201.
7. PPACA §§1301–1322
8. PPACA §§1401–1402.
9. PPACA §1501.
10. PPACA §1413
11. PPACA §2001.
12. U.S. Constitution, Article I, §8.
13. Rosenbaum S, Gruber J. Buying health care, the individual mandate, and the Constitution. N Engl J Med 2010; 363:401-3.
14. PPACA §1001.
15. Pub. L. No. 104-191 (104th Cong., 2d sess., 1996).
16. See: Department of Health and Human Services (US). HealthCare.gov. Understanding the Affordable Care Act: timeline: what's changing and when [cited 2010 Sep 12]. Available from: URL: http://www.healthcare.gov/law/timeline/index.html
17. National Association of Insurance Commissioners and The Center for Insurance Policy and Research. Letter from Jane Cline, President, NAIC, to the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, August 5, 2010 [cited 2010 Sep 12]. Available from: URL: http://www.naic.org/documents/index_health_reform_section_letter_kathleen_sebelius.pdf
18. *United States v Lopez*, 514 U.S. 549 (1995).
19. Public Health Service Act §2723, renumbered by the PPACA.
20. PPACA §1563.
21. PPACA §1251
22. See generally, 75 Fed. Reg. 34538-34570 (June 17, 2010).
23. PPACA §4105.
24. PPACA §4106.
25. PPACA §§1311–1321.
26. PPACA §1311.
27. PPACA §§1301–1304.
28. PPACA §1303.
29. PPACA §2302.
30. PPACA §1101.
31. PPACA Title III.
32. PPACA §§3011–3015.
33. Pub. L. No. 111-5 (111th Cong., 1st sess.)
34. PPACA §§6301–6302.
35. PPACA §9007.
36. National Association of Community Health Centers, the Robert Graham Center. Access denied: a look at America's medically disenfranchised. Washington: NACHC and the Robert Graham Center; 2007. Also available from: URL: http://www.graham-center.org/PreBuilt/Access_Denied.pdf [cited 2010 Sep 12].
37. National Association of Community Health Centers. Expanding health centers under health care reform. June 2010 [cited 2010 Sep 12]. Available from: URL: http://www.nachc.com/client/HCR_New_Patients_Final.pdf
38. PPACA §§4001 and 4002.
39. PPACA §10221.
40. PPACA Title IV, Subtitle B.
41. PPACA Title V.
42. PPACA Title VIII.