ISSUE PAPER

THE AFFORDABLE CARE ACT

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A BRIEF SUMMARY

The federal Affordable Care Act (ACA) is legally designated H.R. 3590, the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152).

The National Conference of State Legislatures (NCSL) outlines the provisions of the ACA in *The Affordable Care Act: A Brief Summary*. The following information is excerpted from the summary. For the complete document, please go to the following NCSL website: http://www.ncsl.org/issues-research/health/the-affordable-care-act-a-brief-summary.aspx.

OVERVIEW AND KEY PROVISIONS

The federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, is commonly referred to as the Affordable Care Act, or as "federal health reform."

Provisions included in the ACA are intended to:

1. Expand access to insurance coverage to approximately 32 million uninsured Americans by expanding both private and public insurance. This expansion is achieved primarily through mandating coverage; creating state-based exchanges to help individuals and small businesses purchase insurance; and expanding Medicaid to cover people with incomes at or below 133 percent of federal poverty guidelines.

2. Increase consumer insurance protections by enacting several insurance reforms including expanding coverage; prohibiting imposing annual monetary caps on coverage; guaranteeing issue and renewal of insurance policies; and requiring or providing for mental health and substance abuse parity.

3. Emphasize prevention and wellness by establishing a Prevention and Public Health Fund; creating the National Prevention, Health Promotion and Public Health Council; requiring coverage of certain preventive care without cost-sharing; increasing the federal share of payment for certain preventive care and services funded through Medicaid; requiring certain restaurants to label menus with calorie information and provide other information upon request; and requiring a federal public education campaign about oral health.

4. Improve the quality of health care and the entire health care system by studying the effectiveness of various medical treatments; demonstrating projects to develop medical malpractice alternatives, reduce medical errors, and develop payment mechanisms to improve efficiency and results; investing in health information technology; improving care coordination between Medicare and Medicaid for patients who qualify for both; and requiring data collection and reporting mechanisms to address health disparities among various populations.

5. Expand the health workforce by reforming graduate medical education training; increasing health profession scholarship and loan programs; supporting training programs for nurses; supporting new primary care models; increasing funding for community health centers and the National Health Service Corps; and supporting school-based health centers and nurse-managed health clinics.

6. Curb the increasing cost of health care by providing more oversight of health insurance premiums and practices; emphasizing prevention, primary care, and effective treatments; reducing health care fraud and abuse; reducing uncompensated care to prevent a shift onto insurance premium costs; fostering comparison shopping in insurance exchanges to increase competition and price transparency; implementing Medicare payment reforms; and testing new delivery and payment system models in Medicaid and Medicare.

Many provisions of the ACA were implemented in 2010 and additional provisions will be implemented over the next several years, with final implementation dates in 2018. The Henry J. Kaiser Family Foundation provides an interactive timeline for the implementation of provisions for the measure at the following website: http://healthreform.kff.org/Timeline.aspx.

Additional information regarding the Affordable Care Act and related topics is available at the following websites:

- United States Department of Health and Human Services: www.healthcare.gov;
- American Legislative Exchange Council: http://www.alec.org/initiatives/health-care-freedom-initiative/;
- The Council of State Governments: http://knowledgecenter.csg.org/drupal/view-policy-areas/1111; and
- NCSL: http://www.ncsl.org/issues-research/health.aspx.

THE UNITED STATES SUPREME COURT RULING

On March 23, 2010, the State of Florida filed a lawsuit in federal district court challenging: (1) the constitutionality of the Medicaid expansion, which required state programs to provide Medicaid coverage by 2014 to certain adults with incomes up to 133 percent of the federal poverty level; and (2) the individual mandate, which requires most Americans to maintain

"minimum essential" health insurance coverage. Florida was joined by 25 states: Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Another group of plaintiffs, including the National Federation of Independent Business and some individual plaintiffs, also filed a lawsuit in Florida. Both cases were considered jointly by the Supreme Court.

On June 28, 2012, the Supreme Court issued a ruling in the consolidated Health Care Cases known as *National Federation of Independent Business v. Sebelius.* The Supreme Court upheld the ACA, holding that the individual mandate was a valid exercise of Congress's taxing power. In its ruling, the Supreme Court left the provisions of the ACA affecting Medicaid intact, holding only that funding that would be received for the existing Medicaid program cannot be conditioned upon a state's agreement to expand Medicaid.

The ACA provides for enhanced federal funding to expand Medicaid eligibility as of January 1, 2014, to include all persons who were not previously eligible for Medicaid and whose income does not exceed 133 percent of the federal poverty guideline. The federal poverty guidelines based on household size may be found at the following U.S. Department of Health and Human Services website: http://aspe.hhs.gov/poverty/12poverty.shtml/. The primary new group included in this expansion is all childless adults whose income does not exceed 133 percent of the federal poverty guideline. With the inclusion of a 5 percent income disregard, the standard for determining whether a person is eligible for Medicaid is set at 138 percent of the federal poverty guideline instead of 133 percent.

Based upon the Supreme Court ruling, states now have the option of whether to expand Medicaid as provided in the ACA. If a state does not expand Medicaid, existing Medicaid funding may not be withheld. If a state expands Medicaid, the state is required to comply with all provisions of the ACA relating to the Medicaid expansion and will be entitled to receive the enhanced funding as previously explained.

States are awaiting guidance from the U.S. Department of Health and Human Services regarding: (1) whether a state may choose to move forward with only a partial expansion of Medicaid and still obtain some part of the funding; and (2) the establishment of a deadline for states to decide whether to move forward with the expansion of Medicaid. As the ACA is currently written, the expansion takes effect on January 1, 2014.

MEDICAID

Medicaid is the state-administered program for medical assistance established in 1965 with the passage of Title XIX of the Social Security Act. The Medicaid program purchases or provides medical services for persons who meet certain eligibility criteria. Medicaid covers three main groups of low-income people: parents and children, the elderly, and the disabled. Under federal Medicaid law, there are certain eligible groups and benefits that must be covered by states. However, states may cover additional "optional" people and services, which Nevada does.

The ACA is designed to expand health insurance coverage to all Americans through a combination of Medicaid expansions, subsidies, tax credits, and mandates. The law also allocates money to improve quality and halts certain widely-criticized insurance practices. The biggest changes come in 2014 when Medicaid expands and states create exchanges to facilitate the purchase of health insurance.

Persons Currently Eligible for Medicaid, But Not Enrolled in the Program

When the individual mandate to obtain health insurance becomes effective on January 1, 2014, it is anticipated that many people who are currently eligible for Medicaid but are not currently enrolled in the program will choose enrollment as their most economical option for health insurance. According to information prepared in March 2010 by the Division of Health Care Financing and Policy (DHCFP), Nevada's Department of Health and Human Services, the Medicaid caseload, under existing law, is anticipated to increase by an average of 5,869 clients in Fiscal Year (FY) 2014 and to continue increasing each year due solely to current Medicaid eligible individuals that determine that Medicaid enrollment is their best option for complying with the individual mandate. The agency projects the monthly caseload may increase by an average of as much as 72,621 clients by FY 2019. Nevada will receive its traditional federal match for this population rather than the enhanced match available for newly eligible persons. Additionally, the cost for these new clients will result regardless of whether Nevada elects to approve the optional expansion of Medicaid eligibility. According to projections prepared by the DHCFP, the State General Fund cost for these new clients will total approximately $11 million in FY 2014, increasing to approximately $129.2 million by FY 2019.

Persons Newly Eligible for Medicaid

The ACA expands Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines by January 1, 2014. According to information provided by the DHCFP in March 2010, if the State expands Medicaid coverage according to the ACA, the Medicaid monthly caseload is projected to increase by an average of 35,891 clients in FY 2014. The DHCFP projects that the monthly caseload will increase by an average of 98,472 clients in FY 2016, but begin to decrease in FY 2017, decreasing to a monthly caseload average of 80,950 clients in FY 2019. Federal funding will be available to states for those newly eligible for Medicaid for three years (2014 through 2016). The enhanced federal funding for the newly eligible persons will decrease to:

- 95 percent for each calendar quarter in 2017;
- 94 percent for each calendar quarter in 2018;
- 93 percent for each calendar quarter in 2019; and
- 90 percent for each calendar quarter in 2020 and in each year thereafter.

States will be responsible for the difference between the actual cost and the federal funding.

ACCESS TO HEALTH CARE

A primary goal of the ACA is to increase access to health care by expanding the number of individuals with health insurance coverage. As coverage is expanded, issues related to the health care workforce and access to primary care in particular are being considered by states across the nation. Following is information related to insurance coverage and the health care workforce in Nevada.

Insurance Coverage in Nevada

The following chart, taken from "Kaiser State Health Facts," outlines the health insurance status for the total Nevada population and the United States population for the period 2009-2010.

Coverage	Nevada		U.S.	
	Number	Percentage	Number	Percentage
Employer	1,341,900	51	149,890,200	49
Individual	132,000	5	14,926,300	5
Medicaid	259,600	10	48,400,200	16
Medicare	298,000	11	38,128,000	12
Other Public (federal)	45,000	2	3,942,500	1
Uninsured	552,400	21	49,903,900	16

The optional Medicaid expansion provided in the ACA expands Medicaid eligibility primarily to childless adults at or below 133 percent of the federal poverty guideline (138 percent with inclusion of the 5 percent income disregard). The following chart, taken from "Kaiser State Health Facts," outlines the health insurance status for adults (aged 19 to 64) with incomes under 139 percent of the federal poverty level.

Coverage	Nevada		U.S.	
	Number	Percentage	Number	Percentage
Employer	78,900	19	9,227,900	19
Individual	30,800	8	3,546,500	7
Medicaid	48,000	12	12,255,300	25
Other Public (federal)	29,900	6	2,305,300	5
Uninsured	24,000	55	21,560,100	44
Total	405,300	100	48,895,100	100

The following websites provide additional information regarding coverage in Nevada:

- Division of Health Care Financing and Policy, Nevada's Department of Health and Human Services: https://dhcfp.nv.gov/index.htm;
- Silver State Health Insurance Exchange: http://exchange.nv.gov/;
- State Health Insurance Assistance Program: http://www.nvaging.net/ship/ship_main.htm; and
- Henry J. Kaiser Family Foundation: http://www.statehealthfacts.org/profileind.jsp?cat=3&rgn=30.

Health Care Workforce in Nevada

Nevada is experiencing significant shortages of qualified health care workers in virtually every health care profession, including health information technicians, laboratory technologists, medical coders, nurses, pharmacists, physicians, and radiology technologists. The situation in Nevada reflects a national trend, and the shortage is of great concern to many because it compromises access to quality patient care.

A 2009 report by The Center for Education and Health Services Outreach at the University of Nevada School of Medicine describes the changing face of the physician workforce in Nevada. Nevada's practicing physicians are characterized by a greater percentage of older physicians nearing retirement. Furthermore, only 5 out of 39 specialties have practicing physicians at a per capita level higher than other states in the region. Only 2 of those specialties have a higher level of physicians per capita than the national average, which leaves Nevada experiencing shortages for most medical and surgical specialties. Also of concern is the fact that Nevada only has 218 physicians per 100,000 of the population while the national average is 307.[1]

Nevada ranks 46th nationally in the number of physicians per resident population, 42nd in dentists per capita, and 50th among all states for both general and specialty surgeons. Similarly, despite important strides taken by State lawmakers earlier this decade to double nursing program enrollment, Nevada ranks 49th among U.S. states in the number of employed registered nurses per capita. Presently, 10 of the State's 17 counties have been designated by the federal government as single county Health Professional Shortage Areas (HPSAs), 11 counties are dental shortage areas, and 14 counties are HPSAs in the area of mental health. While health professional shortages are greater in rural versus urban regions of Nevada, many of the census tracts in the State's three urban counties (Carson City, Clark County, and Washoe County) have been designated as primary medical care HPSAs.[2]

For additional information on the health care workforce in Nevada and nationally visit the following websites:

- Nevada Office of Health Professions Research and Policy, University of Nevada School of Medicine: http://www.medicine.nevada.edu/ohprp/; and

- Health Resources and Services Administration, U.S. Department of Health and Human Services: http://bhpr.hrsa.gov/.

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[1] *Recent Studies and Reports on Physician Shortages in the US*, Center for Workforce Studies, Association of American Medical Colleges, August 2011.

[2] *Access All Nevada: Preserve, Strengthen & Expand Community Health Centers,* John Packham, Ph.D., University of Nevada School of Medicine, and Great Basin Primary Care Association of Nevada, December 2009.