ABSTRACT

EXPLORING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PL 111-148: IMPLICATIONS FOR NEWLY COVERED POPULATIONS AND SERVICES IN HUMBOLDT COUNTY

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The purpose of this research is to take a closer look at the most recent reform to health care coverage and policy implemented in 2013, the Patient Protection and Affordable Care Act PL 111-148. More specifically, this research is a review of the literature on what the Patient Protection and Affordable Care Act means for newly covered populations and services, which in turn will inform local agencies and the service providers of Humboldt County. Humboldt County utilizes a Systems of Care service delivery approach, which is an inter-agency collaboration that provides families with a broad and integrated process to meet their diverse needs. Individuals involved in systems of care, like Child Welfare Services, Public Mental Health, Alcohol and Other Drugs, etc., may now have better access and coverage to much needed services. This research can provide information on what the current health care reforms are and how they may potentially impact the children and families of Humboldt County.
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INTRODUCTION

It is well known that the health care system in the United States is severely flawed. Before the passing of the PPACA in 2010 the health care industry has been free to operate as they so please. This un-checked freedom has allowed the health care industry including insurance companies, hospitals/providers and pharmaceutical companies to employ free market and for-profit tactics on its customers. These tactics have cost consumers in a variety of ways including, financial, mental/emotional/physical health and in the most extreme cases, their life. According to a CNBC health care reporter, Dan Mangan (2013) the number one cause for filing bankruptcy in America is due to medical bills and an inability to pay those bills due to health insurance coverage caps.

Mangan’s 2013 study found the following:
Bankruptcies resulting from unpaid medical bills will affect nearly 2 million people this year—making health care the No. 1 cause of such filings, and outpacing bankruptcies due to credit-card bills or unpaid mortgages, according to new data. And even having health insurance doesn't buffer consumers against financial hardship.

Furthermore, the health care system has historically been a fragmented system of care (Golden, 2011). Discontinuity between service providers, financing, payment options and regulations along with restrictions on information sharing between providers are factors that contribute to a fragmented system (Croft & Parish, 2012). Individuals
with co-occurring mental and physical disorders who require extensive treatment and care have been unable to access much needed services either because they were ineligible for health care or they were stuck trying to navigate a complex, disconnected system of care (Croft & Parish, 2012; Golden, 2011). The PPACA attempts to put an end to the free reign of the health care industry and create a health care system that is effective, preventative, person-centered, collaborative, transparent, more integrated and easier to navigate as well as expand coverage to the most vulnerable and needy populations.

The purpose of this research is to take a closer look at the recent reforms to health care implemented through the PPACA and how these reforms may impact newly covered populations and services and what implications that has for newly covered populations and services providers in Humboldt County. Since Humboldt County utilizes an integrated approach to service delivery, known as Systems of Care (SOC), where agencies collaborate to meet the needs of their clients, understanding the implications of these health care reforms on services and clients is essential. Increased coverage as well as a more integrated health care system could mean that individuals who are involved in Systems of Care like Child Welfare Services (CWS), Public Mental Health (PMH), and Alcohol and Other Drugs (AOD) services can begin to receive the level of care that is required to rehabilitate these individuals and improve client outcomes.

In this review of the literature you will find an extensive overview of what the reforms to current health care are. The PPACA is both in its infancy and a complex document, making it difficult to fully understand what the implications will be for newly covered populations as well as difficult to cover it in its entirety. Additionally, there is
little research on the topic, most of which speculates what implications the reform will have. With that, I have focused on the aspects of the document that I felt would be most relevant to both social workers and client populations. First, I explore literature on the history of the health care system and how it came to be as it is now, literature pertaining to how the PPACA will potentially create a more integrated system of care and implications for populations receiving mental and behavioral health supports. An important component of providing integrated care, particularly in Humboldt County, is utilizing a System of Care approach to provide for clients varying and, sometimes, overlapping needs. In an effort to bring these broad reforms into a more localized and relevant perspective a closer look at how people involved in System’s of Care may be impacted by the new health care reforms is also covered.

Considering the novelty of the PPACA, as well as the complexity, it is important that social workers, and other providers, first and foremost be informed of what the PPACA is. They should also be informed of who may now be eligible for expanded or new coverage, as well as what services may be available to them. Second, more research will need to be conducted later to determine how exactly the PPACA has impacted services and clients. Agencies and communities will need to conduct a needs assessment in order to identify those needs still not being fulfilled by the new health care reforms.
REVIEW OF LITERATURE

Historical State of Health Care

Before the passing of the PPACA in 2010, health insurance companies, driven by free market and for profit tactics, essentially had free reign to provide for customers as they so pleased and often at the expense of the patient. This, however, was not something that happened over night, but has slowly evolved over time. The push for the government to provide health security to all has been an ongoing battle for the last century (PNHP, 1999). In 1910, Theodore Roosevelt gave a speech outlining his “New Nationalism” where he pushed for laws to be created that would protect the health of the working class (Skidmore, 2011). Even though Roosevelt pushed for health care much of the work to reform health care took place outside of the government (PHNP, 1999). The American Association for Labor League (AALL), with initial support from the American Medical Association (AMA) (later on they denied ever supporting the AALL), was one of those outside government forces pushing for the same type of social health provisions (PNHP, 1999; Skidmore, 2011). Unfortunately, opponents like the American Federation of Labor (AFL), the private insurance industry and interest group influence stunted efforts to provide universal health care time and time again (PNHP, 1999).

It wasn’t until after the Second World War, that employers were primarily responsible for providing health insurance, which was offered mostly through for-profit companies, thereby ensuring complexity of insurance exchanges and increasing the costs
After this standard was set, for profit companies and the free market slowly began to dictate what insurance coverage and hospitals would look like. For profit companies began to recruit low risk individuals, offering them the same benefits as community-rated plans but for a lower cost (History News Network (HNN), 2014). However, the moment that these individuals were designated higher risk, they could have their insurance rates increased or be dropped entirely from their provider (Skidmore, 2011). Recruiting low-risk individuals left community-rated plans with the most expensive population of clients to cover (HNN, 2014; Skidmore, 2011). Community-rated plans were now left with two options; adopt these same risk-rating tactics employed by for-profit companies, or go out of business (HNN, 2014; Skidmore, 2011). The result, they adopted a model that focused on market competition rather than one that focused on providing services to their consumers (Skidmore, 2011).

Hospitals and non-profit group-practice plans soon faced the same fate as community-rated plans. Large health care corporations began buying them up and turning them into profit-making machines for stockholders and health care executives (Skidmore, 2011). This focus on fattening the pockets of insurance companies and service providers has made our health care system highly inefficient. This inefficiency is costing patients both monetarily and in some cases, with their very lives. Insurance companies and service providers currently have all the rights and protection, the PPACA aims to redistribute that power back into the hands of the patients, as well as provide protection from being further exploited by the health care system and at the same time reducing costs (Skidmore, 2011).
PPACA Reforms and Implications

The PPACA was enacted by President Barack Obama on March 23, 2010 and is made up of the Affordable Health Care for America Act, the Patient Protection Act and the Health Act. Other laws that were amended by the enactment of the PPACA were the Food, Drugs and Cosmetics Act and the Health and Public Services Act. The purpose of the PPACA is to provide American’s more access to health care, regulate the health care industry and cut back on health care spending (DHHS, 2014; PPACA, 2010).

The PPACA consists of ten titles. In the first title, *Quality Affordable Health Care for all Americans*, there are six subtitles. The first two subtitle’s addressed immediate reform’s that went into effect the moment the bill was passed, which served as temporary fixes until further implementation. The remaining four subtitles addressed mandates, insurance exchanges, rules for businesses and cost assistance (PPACA, 2010). Under the first title, insurance companies can no longer put annual or unreasonable lifetime dollar limits on benefits (DHHS, 2014; PPACA, 2010). According to Croft & Parish (2012) this includes lifetime dollar limits placed on mental health and substance abuse benefits below physical benefits. Essential benefits, like emergency services, hospitalizations, laboratory services, maternity care, mental health and substance abuse treatment, outpatient, or ambulatory care, pediatric care, prescription drugs, preventive care, rehabilitative services (intervention and maintenance), vision and dental care for
children must be included on all new plans (Buck, 2011; Croft & Parish, 2012; DHHS, 2014; PPACA, 2010).

Having services like mental health, substance abuse treatment and rehabilitative services now being considered an essential benefit to be covered by all new plans is a first step to getting the mental health and substance abuse needs of millions met. Under the expansion of Medicaid to newly qualified populations, approximately 32 million, 17.5% of those now covered will have a mental illness or substance abuse disorder (Lind, 2013; Manderscheid, Ryff, Freeman, McKnight-Eily, Dhingra, & Strine, 2010). Furthermore, individuals suffering from mental illness tend to have lower-income rates, public insurance and poorer physical health status (Garfield, Zuvekas, Lave, & Donohue, 2011).

In a study conducted by Garfield et al. (2011) adults with severe mental disorders were more likely than their counterparts to be uninsured, 21% compared with 16.5%. The authors estimate that expansion of health insurance coverage will lead to 1.15 million (4.5% increase) new users of mental health services, 2.3 million users under Medicaid and 2 million users under private insurance (Garfield et al., 2011). Considering the high rate of increase in newly covered populations with mental and physical health needs the PPACA contains a provision known as risk adjustment. Risk adjustment is where Federal and State insurance exchanges move funds from insurance plans with healthier individuals to plans with unhealthier individuals; these plans are reimbursed if the cost of care exceeds a certain level (Barry, Weiner, Lemke, & Busch, 2012; Garfield & Druss,
These regulatory provisions should prevent health insurance companies from employing risk selection tactics (Barry et al., 2012).

Behavioral services such as, substance abuse treatment and rehabilitative benefits have traditionally fallen under the specialty care category, that impose higher fees and more treatment limitations compared to medical benefits, however under the PPACA these services are no longer subject to those same restrictions (Buck, 2011; Pearlman, 2013). Behavioral health services must be offered at parity or similar financial requirements and treatment limitations as general medical benefits (Buck, 2011; Garfield & Druss, 2012; PPACA, 2010). The purpose of this is to create a whole-person centered approach to care, where medical services are not only considered and covered by insurance plans but so are mental and behavioral services (Buck, 2011; Croft & Parish, 2012). This also ensures increased access to and coverage of mental and behavioral health care services, which provides these individuals with co-occurring disorders a more integrated SOC (Croft & Parish, 2012; Ofosu, 2011).

Another provision outlined under title one is all preventative services must be covered by insurance plans with no out-of-pocket cost to the individual. A key characteristic of the PPACA is prevention versus management and treatment of serious health issues, which will improve health outcomes as well as reduce health care spending (PPACA, 2010). The PPACA also extends coverage to dependents. Dependents can now be covered under their parents plan until the age of 26 (PPACA, 2010). Extending coverage to dependents under the age of 26 helps to reduce the amount of uninsured young adults in college or entering the workforce.
A uniform insurance coverage document has been created so that individuals can compare insurance plans when shopping for insurance and thus access the best possible option available (DHHS, 2014; PPACA, 2010). In an effort to make shopping for insurance easier on the consumer, healthcare.gov was created (Kaiser Family Foundation, KFF, 2010; PPACA, 2010). Healthcare.gov is a source where all consumers can learn about the PPACA as well as state based health care marketplaces (KFF, 2010). Along with simplifying the process for signing up for health care coverage, as well as cut down on costs, all medical data is being stored on a centralized database, which also serves to coordinate care better (Croft & parish, 2012; DHHS, 2014; PPACA, 2010).

Insurance companies can no longer drop individuals from their plans, that until the PPACA, they were regularly doing and for arbitrary reasons, like making a simple mistake on the insurance application (PPACA, 2010). Committing insurance fraud is, of course, the exception to the rule. Before the PPACA individuals could be denied coverage for medical expenses and were left with little to no rights to appeal that decision, now consumers have the right to a rapid appeal and are provided assistance during this process (DHHS, 2014; PPACA, 2010). Another arbitrary reason individual’s were being dropped and charged more by insurance companies was because they had pre-existing conditions as well as for their health status, gender or salary (KFF, 2010). The PPACA puts an end to this. Furthermore, the PPACA puts a cap on insurance companies administrative, non-medical, expenditures. If insurance companies exceed that cap, which is 80% of premium dollars, American’s get a rebate (KFF, 2010; PPACA, 2010).
Another important component of the PPACA are the fees that un-insured peoples will have to pay. As of March 31, 2014 everyone is required to maintain minimum health care coverage. If by this date an individual or family has not acquired health insurance they will be required to pay a tax penalty (DHHS, 2014; KFF, 2010; PPACA, 2010). For each month after March that an individual or family has not purchased health insurance or has an exemption the penalty will be applied to their modified adjusted gross income (DHHS, 2014; PPACA, 2010). If an individual or family’s gross income is 133% below the federal poverty line, there is an exemption from this tax fee (KFF, 2010). Exemptions from penalties also exist for undocumented immigrants, incarcerated individuals, members of Native American tribes, incomes below the threshold for filing a tax return, have paid more than 8% of income for health insurance, or for religious purposes (PPACA, 2010). The PPACA tax penalty increases each year, until it maxes out in 2017, where it will only increase at the rate of inflation. In 2014, the fee for an individual is $95 and $47.50 (half of the adult fee) for dependents under the age of 18, or 1% of income grossed, whichever is greater. In 2015, the fee increases to $325 per person or 2%, in 2016, $695 per person or 2.5% (DHHS, 2014; PPACA, 2010).

Small businesses must provide insurance to all full-time employees. Through each states insurance marketplace, small business can purchase group plans utilizing the Small Business Health Options Program (SHOP) (DHHS, 2014; PPACA, 2010). Taxes and tax credits for small businesses are based off of the number of full-time employees and their average annual wages (DHHS, 2014; PPACA, 2010). If by 2015/2016 small businesses have not insured their full-time employees, they will have to make a $2,000
shared responsibility payment tax at the end of the year (PPACA, 2010). If their employees have to get health insurance subsidies through the marketplace then the fee is increased to $3,000 (DHHS, 2014; PPACA, 2010).

Title two, *The Role of Public Programs*, consists of twelve subtitles that address Medicaid, improved and expanded Medicaid coverage, Children’s Health Insurance Programs (CHIP) and the expansion of long-term support services provided through public programs in each state (DHHS, 2014; PPACA, 2010). The first subtitle improves access to Medicaid. Under this subtitle Medicaid is now expanded to cover low-income populations. Eligible individuals include those under the age of 65 (Croft & Parish, 2012), non-pregnant individuals like childless adults and certain parents, and former foster youth under the age of 25 (DHHS, 2014; PPACA, 2010). It also creates a mandatory Medicaid eligibility category for individuals at or below 133% of the Federal Poverty Line (PPACA, 2010). Prescription drugs and mental health services are added as covered services in addition to the essential benefits that are required under all new health plans (DHHS, 2014; PPACA, 2010).

Subtitles three through twelve address enrollment simplification for Medicaid and CHIP, improving services provided by Medicaid, new long-term supports and services options for states, prescription drug coverage, better coordination for individuals who are dually eligible for Medicaid and Medicare, protections for Native Americans and Alaskan Natives, and improved maternal child health services (DHHS, 2014; PPACA, 2010). One important thing to note within these subtitles is the improvements made on long-term supports and services options for states. The PPACA improves home and
community based services (HCBS) by removing barriers that made it difficult for individuals to receive long-term care services, like drug treatment services, and allows those individuals who are receiving HCBS to be fully covered by Medicaid under a State plan amendment (DHHS, 2014; PPACA, 2010). Before States would have to give waivers for full Medicaid coverage to individuals who have higher levels of need, but now States can offer more types of HCBS to those individuals (DHHS, 2014; KFF, 2010; PPACA, 2010). According to Croft & Parish (2012),

The ACA includes provisions to support and expand the medical home through pilot programs and creation of a Medicaid state plan option in which states can permit Medicaid beneficiaries with chronic conditions and serious mental health conditions to designate a provider as a health home.

Another important reform to take note of in Title two is the maternal child health services. Under this subtitle States, Tribes and territories are provided funding to develop and implement evidence-based Maternal, Infant and Early-Childhood home visitation models. Home visitation models that focus on educating families about prenatal, maternal, newborn health, child health and development, and parenting skills can improve infant and maternal mortality rates (DHHS, 2014; PPACA, 2010). Lastly, under this title children who are about to age out of the foster care system are now provided with information regarding the importance of appointing a health care power of attorney in the case that they are unable to make such medical decisions themselves (DHHS, 2014; PPACA, 2010). This education should be provided to them before they
emancipate from foster care through independent living programs and transition planning.

Title three, *Improving the Quality and Efficiency of Health Care* consists of 6 subtitles. Under this title Medicare is preserved, protected and reformed to improve current coverage for both patients and providers as well as reduce costs (DHHS, 2014; PPACA, 2010). Taxpayers will save money through new preventative services that will be offered as well as the reduction of uninsured patient hospital visits. Additionally, in order to help protect Medicare this title puts an end to the overpayment of tens of billions of dollars to health insurance companies. Another improvement made to Medicare is that coverage gaps for prescription drug costs for seniors are now closed (DHHS, 2014; PPACA, 2010). This will in turn, save seniors thousands of dollars.

Community-based care transition programs and hospitals that use evidence-based care transition services will now be funded. These evidence-based care transition services are specifically tailored for Medicare beneficiaries at high-risk of readmission to said facilities (DHHS, 2014; PPACA, 2010). Health care professionals and hospital institutions are provided with incentives to improve care (DHHS, 2014; PPACA, 2010). Increased access to comprehensive, community based, coordinated care by creating a program that funds and organizes the development of community health teams who in turn will support the development of patient-centered medical homes (DHHS, 2014; PPACA, 2010). Lastly, under title three, a team of health care experts will be charged with keeping Medicare going by figuring out ways to reduce costs and improve the
quality of coverage (DHHS, 2014; PPACA, 2010). Essentially this title is created to preserve and ensure that Medicare is provided to our nations elders.

Title four, *Prevention of Chronic Disease and Improving Public Health*, consists of five subtitles. This title focuses on modernizing disease prevention and public health systems, increasing access to clinical preventative services like immunizations, creating healthier communities, and support for prevention and public health innovation (DHHS, 2014; PPACA, 2010). Essentially, the goal is to improve public health by increasing funding for and access to preventative services. Title four reforms include school-based health centers, more preventative services like smoking cessation services for pregnant woman and annual wellness appointments where individualized health plans are created for Medicaid recipients, as well as evidence-based preventative coverage for Medicare recipients (DHHS, 2014; PPACA, 2010). Additionally, seniors will no longer have copay for preventative services and nutritional/oral health information will become more readily available to individuals through education outreach within the community and the workplace (DHHS, 2014; PPACA, 2010).

Title five, *Health Care Workforce*, consists of seven subtitles that deal with the new demands the reform to health care places on the health care workforce. For individuals who are going to school to pursue a career in the health care profession scholarships and loan repayment programs are being created and offered (DHHS, 2014; PPACA, 2010). States are now given the power to recruit health care professionals, which promotes an increase in the health care workforce as well as creating more jobs for Americans. Training and education is provided for all types of public health workers
(Croft & parish, 2012; DHHS, 2014; PPACA, 2010). Community health centers are expanded and funding for these centers is increased (PPACA, 2010).

Title’s six through ten are Transparency and Program Integrity, Improving Access to Innovative Medical Therapies, Community Living Assistance Services and Supports Act (Class Act), Revenue Provisions and Reauthorization of the Indian Health Care Improvement Act. Title six focuses on keeping consumers informed, imposes disclosure requirements that will identify dishonest providers who have defrauded consumers and prevents them from being able to conduct and move their business in from state to state once they have been identified and penalized (PPACA, 2010). Title seven pertains to increasing access to all types of medical therapies rather than ones offered solely for the purpose of profit by drug and insurance companies. It extends discounts on prescription drugs and stops drug companies from keeping effective generic prescription drugs off of the market, provides discounts on prescription drugs to hospitals and programs that provide services to low-income populations and, most importantly, it gives doctors and patients access to more affordable alternatives (PPACA, 2010). Title eight, also known as the CLASS Act, was repealed in January, 2013 and provided Americans with an option to pay into a long-term insurance plan to provide care and services in the event of a disability (PPACA, 2010). Title nine closes tax loopholes, increases taxes for high-income earners in order to pay for increased Medicare and Medicaid coverage, excise tax and fees for insurance companies and the health industry. Consumers will also see more health savings and tax benefits, which will aid in the cost of having health care coverage (PPACA, 2010). Title ten reauthorizes the Indian Health Care Improvement
Act (IHJIA) (PPACA, 2010). The PPACA is estimated to decrease the deficit by approximately one billion dollars over the next ten years.
CONCLUSION

With the expansion of mental and behavioral health care coverage social workers and service providers in Humboldt County can expect to see an increase in client populations (Garfield & Druss, 2012) and should be prepared to assist them in navigating and understanding the new health care system as well as access services provided under the reform. Having a centralized database to shop for insurance will make it easier for Humboldt County service providers to assist their clients in signing up for health care and thus getting access to services. A centralized database will also create true collaboration between Humboldt County service providers who will have access to information on all types of care, physical, mental and behavioral provided to an individual. Making health care coverage a social right by increasing coverage to low-income populations will be beneficial to those below the poverty line, however the burden of those costs will heavily fall in the laps of the middle class (Jacobs, 2011). Furthermore, the obligation for small businesses to provide health care coverage to all full-time employees will be costly and may in fact be of more detriment to them.

Social workers in Humboldt County should be informed about the law, how to navigate the new system as well as what new services their clients may be qualified for. With the PPACA comes an increase in the number of medical homes and treatment centers clients can use and take advantage of for extended periods of time. Knowing where to access funding from as well as how to potentially create more medical homes to meet the needs of our clients is essential as well. Under the PPACA there is enhanced
federal matching funds and assistance available through Medicaid to assist in the
development and utilization of these home health based centers. According to Buck
(2011) public funding for substance abuse services will more closely resemble funding
for mental health and general health care services, where federal dollars from all sources
make up a majority of public spending. While coverage and funding sources are
increasing and expanding, it is unclear exactly how the PPACA is going to play out.
There is funding available through the PPACA to conduct further research on how the
PPACA will play out and how to improve it. Even though we will not know exactly how
this reform will benefit Americans at this time, this health reform is undoubtedly a much-
needed first step to improving the current health care system and the health of Americans.
REFERENCES


