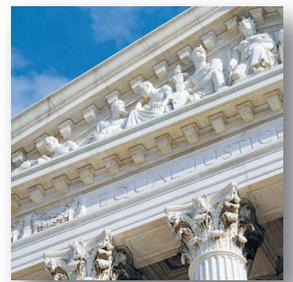


# The Affordable Care Act

## New Features in 2013

E. Paul Larrat, RPh, PhD; Rita M. Marcoux, RPh, MBA;  
and F. Randy Vogenberg, RPh, PhD



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### INTRODUCTION

Legislative and regulatory actions begin in earnest as the implementation of the Patient Protection and Affordable Care Act (PPACA, ACA, the Act) moves forward through the end of this decade. Having survived several legal, financial, and legislative challenges in 2012, the Act remains in force. Most notable among the 2012 events was the narrow affirmation of the Act's constitutionality by the Supreme Court in April; the re-election of the Act's prime sponsor, President Barack Obama; the continued Democratic majority in the U.S. Senate; and the end-of-year agreements that largely resolved the "fiscal cliff" dilemma. Through all of this, most of the provisions of the Act have remained unchanged. However, some significant health reform requirements scheduled

to be implemented in 2013 were either eliminated or altered.

This article summarizes the key milestones and challenges in implementing the ACA in 2013.

### RECENT CHANGES

In 2012, there were numerous occasions on which the actions on Capitol Hill resulted in some subtle yet important changes to the Health Care Reform Act of 2010. In one of the most significant Supreme Court rulings of our generation, most of the Act's provisions were upheld. In the legislative arena, political maneuvering by Congress and President Obama during the August 2011 "debt ceiling" battle and the December 2012 fiscal cliff crisis resulted in several legislative and budgetary changes that affect the Act's implementation in 2013 and beyond.

The constitutionality of several fundamental provisions of the ACA was vetted before the Supreme Court. On June 28, 2012, the justices narrowly upheld the constitutionality of the "individual mandate," a requirement that nearly all Americans obtain health insurance. The Court did, however, limit ACA-mandated expansion of state Medicaid programs. The overall outcome of the ruling was that all ACA provisions would continue to be in effect, with the states allowed to choose their level of involvement in Medicaid expansion.<sup>1,2</sup>

The fiscal cliff, which was mostly eliminated on January 1, had its origins in August 2011, when Congress passed a budgetary measure as part of the agreement to raise the ceiling on the federal debt. As part of the Budget Control Act of 2011, automatic across-the-board cuts of \$1.2 trillion were mandated if other debt control efforts were unsuccessful.<sup>3</sup> The deadline for implementing these cuts has been deferred to March 2013. Although these budget reductions for the most part were not focused on the ACA, several agencies tasked with implementing ACA provisions will face significant cutbacks. There is concern that these cutbacks will effectively limit successful implementa-

tion of several key provisions, including the states' insurance exchanges, federal health insurance cost-sharing subsidies, and grants for innovation of drugs and medical devices.<sup>4</sup>

On January 2, 2013, President Obama signed the American Taxpayer Relief Act (ATRA) into law after a protracted negotiation with Congress to avoid the fiscal cliff of automatic tax increases and cuts in federal expenditures.<sup>5</sup> Two key ACA programs were eliminated. The bill repealed the Community Living Assistance Services and Supports (CLASS) Act, which would have established a self-funding, federal long-term-care insurance program.<sup>6</sup> The ATRA also eliminated most of the remaining \$1.9 billion that could have funded additional Consumer Operated and Oriented Plans (CO-OPs), which were to be member-driven, not-for-profit health insurers.<sup>7</sup> However, the original \$1.9 billion that was lent to 24 nonprofits in 24 states remains intact.

The most salient challenge to the full-scale implementation of the ACA culminated in the national elections of November 2012. A vigorous and passionate political debate about the wisdom of the ACA was a key issue during the congressional and presidential campaigns. An election defeat for the President, coupled with Republican gains in the U.S. Congress, would have ensured a wholesale change or a partial or nearly full repeal of the ACA. The eventual re-election of President Obama and the retention of party control of the two chambers of Congress indicate that health care reform implementation will continue unabated over the next few years.

### MILESTONES FOR 2013

Although the focus of health care reform will be the implementation of key 2014 ACA provisions, several mandates become effective in 2013. The fiscal cliff agreement prevented a reduced fee schedule payment to Medicare physicians and practitioners, but eliminating the 26.5% reduction cost the federal government approximately \$30 billion. This

*E. Paul Larrat is Professor of Pharmacoeconomics at the University of Rhode Island, College of Pharmacy in Kingston, R. I. Dr. Larrat was a 2010–2011 AAAS/AACP Congressional Fellow, serving as a health policy advisor to the office of Senator Ron Wyden (D-OR).*

*Rita M. Marcoux is Clinical Associate Professor of Managed Care Pharmacy and Director of Pharmacy Outreach Programs at the University of Rhode Island, College of Pharmacy, in Kingston.*

*F. Randy Vogenberg, the editor of this column, is a pharmacist with a doctorate in health care management. He is a member of P&T's editorial board, a fellow of the American Society of Forensic Examiners, and a fellow of the American Society of Health-System Pharmacists. He has lectured on health care policy and law and has presented continuing education seminars on risk management in the health professions throughout his career. Dr. Vogenberg is Principal at the Institute for Integrated Healthcare in Sharon, Mass., and Adjunct Professor of Pharmacy Administration at the University of Rhode Island, College of Pharmacy, in Kingston. His e-mail address is randy@iilh-online.com.*

“doc fix” will be financed largely through reductions in payments to hospitals by two mechanisms. Over the next 10 years, hospitals will receive smaller payments for overnight or inpatient care through a downward adjustment in annual base pay increases, and their disproportionately shared payment will be reduced by \$4.2 billion. These changes do not eliminate the scheduled physician reduction but merely postpone its implementation. The additional sources needed to fund this decision will result in implementing competitive bidding on diabetic testing strips bought in retail pharmacies, reducing risk-adjusted payments to Medicare Advantage (i.e., Part C) plans, and readjusting bundled payments for end-stage renal disease.<sup>8</sup>

Effective January 2013, state Medicaid agencies that provide preventive services to beneficiaries with no copayments receive a 1% increase in federal matching payments. Federal funding will finance the increase in payments (100% of matching Medicare rates) to primary care providers that began on January 1 and will continue through December 2014. States will also benefit from two additional years of federal funding for their Children’s Health Insurance Program (CHIP).<sup>9</sup>

Some provisions affect Medicare. The agency’s bundled payment pilot program will be established to assess the value in bundling payments for all services provided for an episode of care. The intent of this provision is to achieve savings by promoting collaboration among all providers. Employers who offer their own prescription drug programs for Medicare-eligible retirees will lose the tax deduction for their drug subsidy payments. The Medicare D drug coverage gap continues to close, with manufacturer discounts and lower coinsurance payments by beneficiaries.

Another set of provisions in 2013 largely affects employees. The maximum annual Flexible Spending Account (FSA) contribution, which reduces taxable salary, is now \$2,500, down from \$5,000 for 2012. Medicare payroll taxes are increasing by 0.9% for single individuals on earned income exceeding \$200,000 and for couples filing jointly on earned income exceeding \$250,000. An additional 3.8% net investment income tax on higher earners is scheduled to be implemented.<sup>10</sup>

Two provisions may affect health care costs for individuals. The threshold for

itemizing deductions of unreimbursed medical expenses has been raised from 7.5% to 10% of adjusted gross income, and an excise tax of 2.3% is now imposed on the first sale for use of any taxable medical device (generally used by physicians and hospitals). Exceptions include eyeglasses, contact lenses, hearing aids, and any type of device generally purchased by the public at the retail price for individual use. Although the excise tax is paid by the device manufacturer, higher costs could eventually be passed on to the public.<sup>11</sup>

## CONCLUSION

Challenges to the ACA were averted in 2012, and the balance of power in Washington, D.C., remains unchanged; as a result, implementing health care reform changes can now move forward. At the same time, the passage of the ATRA to avert the fiscal cliff brings a different set of adjustments for health care in government-funded programs. Revenues to hospitals will be lower, payments to physicians will be modified (although this is not the solution they had hoped for), and more patients will be covered by government programs such as Medicaid. Medicare payments will continue to be bundled, and shared savings program strategies will continue, with an apparent trend toward some form of fixed reimbursement.

For individuals, payroll tax increases and medical deduction changes in the tax code will add some economic strain that might limit their use of health care services.

For drug and device companies, Pharmaceutical Researchers and Manufacturers of America (PhRMA) will continue to plug the “donut hole” in Medicare Part D, and device firms will start paying an excise tax on their products.

For pharmacists, we can expect to see more patients in the health care system as access broadens and as more medication use by the baby-boomer generation grows. Hospitals and health care systems, faced with economic challenges, will be seeking new ways to increase revenue by involving pharmacy services. Pharmacists will need to be aware of what is happening in their own states in response to federal implementation of the ACA. In addition, they will need to stay abreast of drug shortages, comply with regulations for sterile compounding, and become familiar with the expected increase in

auditing of all aspects of the health care business. There is no shortage of challenges for hospital committees in 2013; the key will be to confront opportunities with innovative solutions in a broad, fast-paced legal environment.

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