Facing skyrocketing costs and the erosion of health care access for small businesses and workers across the nation, in March 2010 Congress enacted the most sweeping transformation of the health care system since Medicare and Medicaid were established 45 years ago.

The goal of the Patient Protection and Affordable Care Act (ACA) is to ensure access to affordable quality health care for families and businesses who currently have health insurance and for those who do not. To achieve this goal, the law includes:

- Providing tax credits for businesses and non-profits with 25 or fewer employees that offer insurance, and penalties for employers with more than 50 employees that don’t.
- Imposing new regulations on health plans in the private market to offer coverage to individuals regardless of health status, spend most premium dollars on health care, and end other policies that limit coverage.
- Creating new state-based health insurance exchanges to facilitate the purchase of insurance and improve competition between health plans.
- Requiring that individuals maintain health insurance enforced by a federal tax penalty.
- Expanding Medicaid to low-income individuals.
- Providing premium subsidies to individuals with incomes above the Medicaid level.
- Providing states with immediate resources to create or support high risk pools to cover individuals who can’t get insurance in the private market due to a pre-existing condition, until the 2014 coverage expansions are in effect.

The law also contains measures that should reduce health care spending while improving quality of care, such as expanding access to preventive services, stopping payment for health care acquired infections, reducing fraud, accelerating development of home and community-based services for individuals needing long-term care, reducing unnecessary rehospitalizations and promoting development of alternative payment strategies to reward quality and outcomes for patients instead of the number of procedures and visits.

While the ACA creates the framework for these reforms, much of the implementation is left up to the states – which have the flexibility to make key decisions and the responsibility for much of the law’s implementation. The law is complex and will be implemented over several years, with all the major provisions taking effect by January 2014.
The Pennsylvania Context

When fully implemented in 2014, the ACA will greatly expand access to affordable health care for Pennsylvania families and individuals, with fewer than 4% of Pennsylvanians remaining uninsured when the law is fully implemented.

But in order to reach the families and businesses that the law is intended to reach, Pennsylvania has many decisions to make and much work to do. It has the opportunity and the challenge to create a state-of-the-art web portal that provides consumers with information and tools needed to compare options for health coverage and to learn about and obtain a determination of eligibility for tax credits and reduced cost sharing.

And as Pennsylvania achieves near-universal health care coverage, it will be imperative that it do so in a high-quality, affordable and sustainable way for our families, businesses and state government. It is projected that the state will pay $7.3 billion in health care costs this fiscal year for the Legislature, its employees and retirees and for other state-funded care—nearly one-fourth of the general fund. Implementation of the ACA provides an historic opportunity to not only provide affordable health care coverage to almost one million uninsured Pennsylvanians, but also to transform how health care is paid for and delivered in the Commonwealth.

While Pennsylvania faces a serious budget deficit, billions of federal funds are available to help finance the efforts Pennsylvania must undertake to implement ACA. Many requirements are funded 100% with federal funds, while others require only a small state match. The Act also provides opportunities for Pennsylvania to expand implementation of the primary care medical home and pilot promising new ways to organize care to hold down costs and enhance quality.

Health care reform will generate substantial net savings to Pennsylvania over the next ten years. Some initiatives will increase the state’s costs, while other components, like greater federal funding for CHIP, will result in substantial savings and new revenues.

Provisions Already In Effect

Some of the reforms have already been implemented. Pennsylvania has applied for and received a grant to create a high risk pool for those who have been uninsured for six months and who have a listed pre-existing condition. PA Fair Care has 2,046 enrollees as of December 1, 2010 receiving affordable care for their chronic conditions. The Pennsylvania Insurance Department has also applied for and been awarded $1 million each for planning for the insurance exchange, improving rate review, and providing consumer assistance with health insurance issues.

For most plans with plan years beginning on or after September 23, 2010 Pennsylvanians who have health insurance can now really count on it when they become sick or injured—no more lifetime limits, annual caps or arbitrary cancellations. Children cannot be denied coverage because of a pre-existing condition. Parents with employer-based coverage may add their uninsured adult children up to age 26 as dependents on their coverage. Many small businesses with lower wage employees are eligible for tax credits
for the 2010 tax year for providing health care coverage to their employees. New plans must cover preventive health services without charge to the consumer.

Timeline for Additional Changes

Many additional provisions of the ACA will require decisions at the state level and significant planning for implementation. The major provisions are described year-by-year below:

2010

- PA Fair Care offers health insurance to people with pre-existing medical conditions who have been denied coverage. This temporary program will be funded through January 1, 2014 when state-based health insurance exchanges will be available.
- Children cannot be denied coverage due to pre-existing conditions
- New insurance plans must include free coverage of preventive care.
- Young adults up to age 26 can be added to their parents’ insurance plans.
- Pennsylvania received $1 million in a Health Insurance Exchange planning grant.

2011

- Insurance companies are required to spend 80 to 85% of consumers’ premiums on medical care and efforts to improve quality, rather than profits, marketing and administration. Companies that do not comply will have to give rebates to their customers.
- Small business tax credit begins. Qualified small businesses will receive a credit of up to 35% of their health care premiums paid when filing their 2010 taxes.
- Several programs to encourage home- and community-based care will begin, including the voluntary CLASS long-term care insurance program. Participating employers will automatically enroll employees and employees will be able to opt-out of the program.
- Community Care Transitions Program will offer grants aimed at high-risk Medicare beneficiaries who are hospitalized to avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities.

2012

- By January 2013, the Secretary of Health and Human Services will make a determination of Pennsylvania’s readiness to implement a state Health Insurance Exchange.

2013

- The Health Insurance Exchange must be operational by July and be prepared for an open enrollment in the fall, including the qualification of health plans.

2014

- Annual limits on health insurance claims are eliminated.
- Health insurance plans can no longer deny coverage due to pre-existing conditions.
- Health plans can no longer charge higher rates based on gender or health status.
- Individual mandate to have health insurance coverage takes effect.
- Individuals not offered coverage by their employer may compare and purchase qualified health plans through the exchange and apply for premium assistance.
- Medicaid expansion covering individuals with income up to 133% of the FPL begins, with 100% of the additional costs for expansion group paid for by the federal government for the first three years.
• Low and middle income families will receive tax credits that can help purchase health insurance through the exchange.
• Small business tax credit is expanded.

2015
• The state exchange must demonstrate that it is financially self sufficient.

2016
• Exchanges must cover employers with up to 100 employees if they have not opted to do so already.

2017
• Exchanges may expand to the large group market.

Commonwealth Health Care Reform Implementation Advisory Committee

The implementation schedule set forth in the ACA is extremely ambitious. To design policies and program changes that meet Pennsylvania’s unique needs and that adhere to the law’s timelines, planning and work needed to start quickly. On July 20, 2010, Governor Edward G. Rendell signed an Executive Order creating the Commonwealth Health Care Reform Implementation Advisory Committee as a non-partisan, broadly representative working group to make recommendations on how to implement the health care reform law to best service Pennsylvania’s taxpayers, small businesses and working families.

This committee is comprised of 47 members including consumers, small businesses, advocacy organizations, health care providers, health plans, hospitals, members of the Legislature and the Executive Branch. This group was charged with providing advice on:

1. Design of the optimal programmatic model for the commonwealth’s High Risk Pool.
2. Design of the optimal organizational model to support a customer friendly and efficient health benefit exchange.
3. Identification of technology, organization and process improvements necessary to support the implementation of all state obligations under the Act.
4. The strategic plan for the implementation of the Act.
5. Legislative action necessary to enable full implementation of the Act and draft legislation for discussion with appropriate members of the Legislature.

Meeting eight times over nearly six months, the members explored the major issues the state will need to address as it implements the federal law, hearing from national experts and learning from each other. After initial background work, the group worked together to develop broad strategic goals for implementation of health care reform in Pennsylvania. The goals adopted by consensus of all members of the Advisory Committee are:

1. To facilitate and encourage the purchase and provision of affordable health care coverage.
2. To improve the health care coverage marketplace by structuring the exchange to promote competition on the basis of value and to avoid adverse risk selection.
3. To provide a one-stop, easy to use, accessible portal for consumers and businesses to learn about and compare options for coverage.

4. To provide a unified and integrated approach for consumer application and enrollment in all other health and human services for which people may be eligible.

5. To assure administrative efficiency and to maximize the leveraging of all administrative funding.

6. To ensure increased access to quality health care through a diverse, robust network of health care providers, including safety net health care providers.

7. To support the goals of health care reform: transformation of the health care system to support improved quality of health care and reduced cost of care.

The Advisory Committee organized itself into three subcommittees to develop goals and recommendations for approaching creation of a health insurance exchange, increasing access and enrollment, and implementing other health care reforms to enhance quality and contain costs.

Each subcommittee reviewed its charge and the relevant strategic goals adopted by the Health Care Reform Advisory Committee; received background information geared to inform members about the current status of state policy and infrastructure and to examine potential options. Feedback was solicited throughout the process from all members of the larger Advisory Committee, and drafts were posted on the website to solicit public input.

These diverse constituencies found extensive common ground on a range of difficult issues that will need to be addressed to implement the reforms in the ACA. These consensus positions are summarized below and appear in greater detail in the three subcommittee reports attached to this document. In the areas where they did not find consensus, the subcommittee reports detail the conflicting opinions between the majority and minority.

The findings and recommendations that follow are intended to serve as a blueprint for Pennsylvania’s implementation of the Affordable Care Act and a road map for achieving the strategic goals for Pennsylvania’s exchange.

**Health Insurance Exchange**

**Challenge:** The Commonwealth must establish a state-based Health Insurance Exchange by mid-2013 or the federal government will implement this component of ACA in Pennsylvania. If Pennsylvania elects to establish an exchange, there are a multitude of policy, information technology, enrollment, and synchronization issues that will need addressed. The Exchange Subcommittee focused on broad policy issues associated with whether and how the state should operate a health insurance exchange.

**Recommendations**
Consensus was reached on many aspects of the exchange. The committee recommends that the state create an exchange and that it have a consumer-oriented mission. While no consensus was reached, the majority felt that this exchange should be
an independent public agency or authority that is governed by a diverse board with restrictions on conflicts of interest and strong management team. Additionally, it was agreed that qualified individuals should be able to access insurance inside and outside the exchange and that plans that are offered in both would have the same premiums and be subject to consistent Insurance Department rate review. Lastly, while consensus was not reached, the majority supports an exchange that has authority to negotiate as an active purchaser to drive the best value for employers and individuals.

Access and Enrollment

Challenge: State-operated exchanges must meet the needs of a wide variety of customers, from individuals who qualify for premium subsidies, to small businesses seeking to purchase insurance for their employees and applying for tax credits. States will be expected to streamline and simplify enrollment processes, maintain state-of-the-art web portals, and provide additional assistance to those in need. The Access and Enrollment Subcommittee focused its work on formulating a vision for how the exchange should support consumers – both individuals and businesses.

Recommendations
Complete consensus was reached by the committee on the subcommittee report. Major recommendations include creation of a robust, state-of-the art web portal for individuals and businesses to provide clear and understandable information about coverage available through the exchange and a full-service customer services call center to assist consumers. Also, the group recommends the exchange have a single application for all insurance programs with integrated eligibility processes. Continuity of care was of particular concern for low-income individuals who may be transitioning in and out of Medicaid into subsidized coverage. For example, it was recommended the Medicaid and non-Medicaid plans create partnerships to assure access to the same providers. In this context, the state should carefully examine the Basic Health Plan option which may save the state money while better coordinating benefits for this gap population. Lastly, the group recommends the Commonwealth take full advantage of opportunities to support long-term care reform.

Other Major Reforms
Challenge: Expansion of health insurance coverage should be accompanied by measures to improve the ability of the health care system to provide quality care in the most effective and cost-efficient manner possible. In addition to making changes in Medicaid and Medicare that will improve quality and reduce costs, the ACA provides many tools that states can use to make progress on this overarching goal. The Other Major Reforms Subcommittee identified critical areas of focus for improving quality, reducing costs and assuring access to services for the newly insured.
**Recommendations**
Complete consensus was also reached by the Advisory Committee on this subcommittee report. Major recommendations for the incoming administration include reforming how the state pays for health care (PEBTF, Medicaid, CHIP, adultBasic, Corrections, etc.) so that providers are paid based on the efficient use of resources while providing high quality care – instead of simply for the number of procedures they perform or patients they see. In addition, the report recommends continuation of the Chronic Care Initiative, which is proven to save money and improve care and which currently includes 900 primary care practitioners which serve more than 1.4 million patients, so that it is the norm for practice in the Commonwealth. The report also recommends the state provide additional support for safety net providers and provide better supports for consumers to make informed decisions about options for treatment and take a more active role in their care. Finally the report recommends measures for taking the state’s efforts to reduce medical errors to the next level, to improve end-of-life care and to ensure the work-force can meet emerging health needs.