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Affordable Care Act: A review and discussion of its impact on healthcare today, and a primer for pharmacists

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Abstract

In the midst of countless healthcare debates, the Patient Protection and Affordable Care Act is written into legislation as a possible solution to the United States's rising healthcare costs. Individualized into nine titles, the act sought to provide additional coverage to millions of Americans while cutting down healthcare costs through numerous provisions effective into 2020. While the act has been challenged publicly and privately by the states, many healthcare professionals today, let alone the average American, are unaware and uneducated of what comprises the act, as well as the impact in which it has on the future of healthcare in the United States. With an increasing role of patient care placed upon pharmacists today, an understanding of the PPACA allows us to provide extensive answers to questions in which our patients may have.

Introduction

As one of the largest reforms to the American health care system since the enactment of Medicare and Medicaid through the Social Security Act of 1965, the Patient Protection and Affordable Care Act (PPACA) breathed life on March 23, 2010 when it was signed into law by President Barack Obama. While only two years have passed since the enactment, much of the act has already been initiated through numerous effective provisions, affecting healthcare professionals everywhere. While the main focus of the PPACA is aimed primarily in decreasing the number of uninsured Americans and reducing the overall costs of health care, there are many other aspects to the legislation including the transition from fee for service payment to a pay for performance system, the establishment of free preventive services and annual wellness visits, as well as innovations in health workforce training and recruitment, just to name a few. This report focuses on the main aspects of this legislation, while discussing the impact in which each makes in the pharmaceutical field. When President Obama was re-elected for a second term on November 6, 2012, it has become evident that the PPACA will continue to shape America's healthcare in the upcoming years. The average American today, whether a healthcare professional or not, should educate themselves in the common aspects of this reform to better understand how their healthcare will be affected in the near future. Moreover, pharmacists should be very knowledgeable in order to answer patient questions.

History

The Patient Protection and Affordable Care Act (PPACA) was originally introduced in the House of Representatives on September 17, 2009 as H.R 3590, sponsored by Rep. Charles B Rangel.¹ After the bill was approved by the House of Representatives in 20 days, the measure went to the Senate

on October 8, 2009, which was amended to the House's bill. Focusing on its own version of the bill, the Senate's Amendment to H.R 3590 was passed on December 24, 2009 by a vote of 60-39.² Despite various proposed amendments and motions which were both considered and rejected between the Senate and the House, the Patient Protection and Affordable Care Act was surprisingly passed by the House on March 21, 2010 by a narrow margin of 219-212, ending a year of embittered partisan debate. In what became a historic victory in the struggle for health care reform for the President during his first term, President Obama signed the bill into law on March 23, 2010.³ Despite the signing of the law, perhaps the most resounding triumph of the PPACA came on June 28, 2012, when the U.S Supreme Court, by a vote of 5 to 4, upheld the health care law which required Americans to either buy/obtain insurance or pay a penalty, as a government tax will be implemented to those who doesn't have health insurance in the future.⁴ While the focus of healthcare reform will shift back to the political arena, the court's ruling was considered a success for the Obama administration, as the primary aspect of the law was upheld as constitutional.

The Patient Protection and Affordable Care Act

Divided under nine titles, the PPACA addresses nearly every component of the healthcare system. After its enactment in 2010, the PPACA contains provisions that became effective immediately, 90 days after enactment, as well as provisions phased in until 2020. Focusing beyond its primary goal in ensuring that over 94% of Americans will be provided healthcare coverage by 2020, the PPACA also addresses additional provisions in Medicare and Medicaid, most notably through the Medicare expansion and the filling of the donut hole under the Medicare Part D prescription drug program.

American Health Benefit Exchange

Effective in 2014, the PPACA requires almost all Americans to have health insurance. A qualified health plan, which is to be offered through the new American Health Benefit Exchange (AHBE), must provide essential health benefits which include cost sharing limits. The AHBE will be established, certified and operational by each state in 2014 in order to help individuals and small employers have the opportunity to compare the various tiers of plans, limit price variation, as well as to educate on AHBE's regulations on the progressive elimination of lifetime and annual limits.⁸ In order to make coverage affordable to all Americans, refundable tax credits will also be available for anyone with incomes between 100% to 400% of the federal poverty line (FBL).⁸ The federal poverty line through 2012 was approximately \$11,170 for a one person household and \$23,050 for a family of 4.¹⁶ However, there is a time limit in which an individual must purchase health insurance, for penalties will be imposed by the government if minimum essential coverage is not maintained by January 1, 2014. This penalty will also increase as the years go on, from \$95 per individual in 2014, up to \$750 per individual in 2016.⁶ If penalties are imposed on a family, the amount would be no more than \$285 per family or 1% of income, whichever is greater. This amount is expected to substantially increase to \$2,085 per family or 2.5% of income, if a family continues to choose not to be covered by a health insurance.⁶ While the political issue at hand is whether the federal government's exchanges will be able to provide support for individuals in states that fail or refuse to establish their own exchanges, the greater fear will be the impact in which an extension of health insurance coverage to more than 30 million Americans will have on hospitals and clinics around the country. While more patients are being admitted, this subsequently leads to an increased number of medications to be filled and compounded. There is also added frustration from patients who cannot schedule their doctor's office for months due to this matter. However, a higher hospital admission rate simply does not mean that more patients have fallen ill, but simply that more individuals are now seeking care. While this may result in a longer waiting time for a doctor's visit to be scheduled, it may also decrease the chance of a future emergency room visit. As a result, while the imminent impact of an extended health insurance coverage may lead to higher consensus at hospitals or scripts filled at a retail pharmacy, the futuristic impact may offer lower acute hospital visits, expansions of healthcare systems in order to accommodate the needs of more health services, as well as increased retail pharmacy chains opened leading to increased employment.

Small Employer Tax Credit

One of the provisions of PPACA is to reduce premium costs for millions of working families and small businesses by

providing hundreds of billions of dollars in tax relief. For small businesses, a business health care tax credit is available if the qualified employer has fewer than 25 full time employees, an average annual wage of employees less than \$50,000, and with employers paying at least half of the insurance premium.⁶ During tax years 2010 to 2013, a maximum credit of 35 percent for small business employers and 25 percent for small tax exempt employers such as charities can be claimed.⁶ For small tax exempt employers, the credit may be received as a refund as long as it does not exceed their income tax withholding and Medicare tax liability. In addition, if one is a small business employer who doesn't owe any tax during the year, the credit can be rolled over to the next tax year.⁵ While the tax credit does provide some relief for small businesses, a recent trend has been seen in which small businesses cut down on the number of employees hired in order to become eligible as a small business. For privately owned medical practices, independent pharmacies, and local pharmaceutical companies, this containment may limit the growth of these future businesses. In addition, under a different title of the PPACA, businesses with more than 50 workers are required to provide health care coverage for full time employees and those working more than 30 hours per week, or else face new federal taxes for not doing so.⁵ While this may not slow down the hiring of employees for most businesses in anticipation of its implementation, it can lead to a decrease in full time positions available. While hiring only part time employees to fill the gaps, a business may see this as the only viable option to not suffer the act's penalty. In the healthcare system, an increased part time staff may suggest more jobs to the public. However, it may also introduce a lack of consistency among healthcare workers, as one may constantly strive to find a better job. Ultimately, this may lead to increased miscommunication and the lack of fluidity any organization needs in order to perform at its optimal rate.

Lifetime and Annual Limits

Under the PPACA, there are now prohibitions on health plans from putting a lifetime dollar limits on most benefits received. The law restricts, and will phase out, the annual dollar limits that a health insurer can place on "essential health benefits. Effective immediately since enactment, lifetime limits have already been banned. In addition, the PPACA imposes a three year phase out of annual dollar limits in amounts no less than \$750,000 in 2011, to 1.25 million in 2012, to 2 million in 2013, and finally to no annual limit beginning January 1, 2014.⁷ The health reform also ends lifetime limits for up to 105 million Americans who had been living under the fear that their chemotherapeutic or immunosuppressive medications may one day be no longer covered.⁷ Under the same title of the act, which will be further described later, the PPACA also mandates that

preventative services such as cancer screenings be provided to adults, children and young women across America. While the prohibition of a cap on out of pocket expenses may drive up the cost of medications for insurance plans in the future, free preventive care services are the most cost effective ways in reducing future hospital visits and disease prevention. In the past, one of the biggest population groups that struggled with annual benefit limits was cancer patients. Because chemotherapy is a necessity in the treatment for these patients, it increased the pressure of many cancer patients when they approached near their annual or lifetime limits. However, under the PPACA's restriction on these limits, much weight has been lifted off their shoulders. Looking ahead, the availability of preventative services such as mammograms may also lead to earlier detection of breast cancer and more effective initial treatment. Ultimately, this will not only save lives, but also decrease the chances of requiring lifelong treatment if a patient's condition becomes dormant.

Young Adult Coverage

In one of the less controversial policies established by the PPACA, the law allows children under the age of 26 to continue to be covered by their parent's health plan. By allowing children to stay on a parent's plans, the law makes it easier and more affordable for young adults to get health insurance. Especially with youth unemployment at a higher rate over the past years, along with the inability of many entry-level college graduates to obtain health insurance due to having only part time positions, this act allows for a more optimistic outlook into adulthood. With free preventative services now provided for children such as depression, HIV and dyslipidemia screening, the lack of a burden in obtaining health insurance for adolescences may lead to increased checkups and visits from their primary care physicians.⁹ While this may drive up the cost of healthcare in the near future, preventative care is ultimately cost effective and may lower an adolescent's risks for future diseases.

Medicaid Expansion

One of the main establishments of the PPACA involves provisions towards the improvement and expansion to Medicaid. Effective January 1, 2014, Medicaid's eligibility requirements will differ greatly, as it will be expanded to include all American citizens between the ages of 19 to 65 years old with incomes up to 138% of the (FPL) Federal Poverty Line (representative to an annual income of about \$14,856 for one individual).¹⁰ Before the enactment, each state operates under their own Medicaid program that provides health coverage for lower income people, families, and children, the elderly and people with disabilities. A key difference between the two eligibilities was that poverty was never the only aspect considered in former Medicaid

requirements. Under new eligibility requirements, states are expected by 2014 to be participants to the Medicaid Expansion. Unfortunately, not every state is mandated to participate in the expansion, after the U.S Supreme Court ruled that states cannot be penalized by the government for refusing to expand Medicaid.⁴ However, states that choose the option of expansion would receive full federal assistance for the added spending in the first three years of the expansion, with variable assistance in the later years based upon the populations in which they choose to cover.¹⁰ This becomes a very enticing offer, as large increases in coverage and federal funding will be seen in exchange for a small increase in state funding. If the PPACA succeeds in having every state participate in the Medicaid expansion, it is expected to result in additional coverage of over 11.2 million Americans in the first few years, on top of the estimated 50 million Americans who were originally enrolled in Medicare.¹¹ If every state chooses to enroll in the Medicaid Expansion by 2014, hospitals might actually see increased revenues and state assistance as the years go on. One of the main reasons is due to the fact that higher levels of coverage will allow states to reduce payments they make to support uncompensated care cost, especially from emergency room visits, that accumulate from hospitals treating uninsured patients.¹¹ In addition, increased Medicaid patients will hopefully encourage more low income Americans to seek medical and preventative care for their health and disease states. In research conducted by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, it is projected these cost would drop by about \$183 billion over the next 10 years, while hospitals would take in \$314 billion more in revenue than they would if no states expanded Medicaid.¹¹ By comparisons, many patients today continue to pay out of pocket fees due to a lack of insurance for their medications at retail pharmacies, leading to decreased compliance for refilling or taking their medications. A lack of compliance in medication usage ultimately returns a patient to their primary care physician or emergency room for readmission of their disease. Hopefully, the increased coverage for Medicaid patients will defeat this cycle, allowing more patients to be compliant with filling for their medications and reduce the number of readmissions and missed refills at pharmacies and hospitals everywhere.

Community First Choice Option

While the PPACA tackles issues about the younger population, it also does so for the elderly, most notably those who are covered through Medicaid. As one of the provisions of the health reform, a new state plan option, known as the Community First Choice Option, was created and made available on October 1, 2011 to provide home and community based services for Medicaid patients.¹² States

who choose to take up the option will receive a 6% increase in federal matching payments (FMAP) for costs associated with the program.¹² Under the benefit, states must cover services to help Medicaid eligible individuals accomplish activities and instrumental activities of daily living (ADLs and IADLs) such as eating meals, dressing up clothes, walking and using the bathroom. In addition, states must also include secondary systems such as personal emergency response systems, pagers, and alarms to ensure continuity of services in the event that staffing such as doctors and nurses are not available to assist for these individuals at any moment.¹² The increased federal matching payment is a strong incentive for states to take up this new option and to expand home and community based care services in Medicaid. This expansion can impact the healthcare system in many ways. Increased community and home based services increases the need for trained healthcare professionals, especially nurses. Additional joint cooperation between hospitals and pharmacies, especially mail order, with home services can further create a medical home model for patients, as more patient centered care can be provided. As healthcare costs are the highest among lower class populations in the United States, the establishment of programs such as Community First Choice Option and Medicaid expansion builds around the idea that increased insured care for these groups of patients may help improve quality of life on the patient's side, while lowering hospital expenses due to lower readmission rates to hospitals on the healthcare side of the equation.

Payment to Quality Measures in Medicare

Readmission rates have been one of the most detrimental factors in a hospital's yearly expenses. The expenses are due to a combination of additional tests, treatments and medications needed to retreat these patients. The national average readmission rate has remained steady at around 19 percent for several years, even after many hospitals have worked harder to lower theirs.¹³ As a result, nearly 2 million Medicare patients are readmitted within 30 days of released each year, costing Medicare over \$17 billion.¹³ In order to tackle this issue, the PPACA implements a penalty on hospitals as an establishment of increased quality measures. Currently, the penalties are based on the frequency that Medicare heart failure, heart attack and pneumonia patients were readmitted within 30 days between July 2008 and June 2011.¹³ The penalty will be deducted based on the reimbursements a hospital can claim through in October 1, 2012. In 2012, the current maximum penalty that a hospital can receive through Medicare reimbursement is at 1 percent of that claim. However, that penalty percentage will increase to 2 percent of regular payments starting in October 2013, and then to 3 percent the following year. Based on the reports given by the Center for Medicare and Medicaid

Services (CMS), 2217 hospitals will be penalized for excessive readmissions.¹³

In contrast, Medicare will also provide quality bonuses to hospitals based on the quality of care that they provide, along with patients' satisfaction during their stays. In order to fund for this incentive, Medicare will cut payments to hospitals by 1 percent and set that money aside for a bonus pool.¹³ Hospitals that receive better ratings or show improvements as opposed to previous years would earn these bonus payments. Like the penalties system imposed, this bonus pool would increase by 2-3 percent of Medicare payments in the later years. 70% of this bonus pool will initially be based on how often a hospital follows guidelines based on 12 clinical care measures.¹³ These guidelines would include preventative and treatment protocols followed for each specific disease state. The remaining 30% of the bonuses will be determined by how patients rate hospitals on their experiences based upon 8 dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems initiative (HCAHPS).¹³ Medicare will provide hospital conducted surveys for patients which consist of questions concerning how the level of communication between them and nurses and doctors, the cleanliness of their rooms and how well their treatment was managed.

The transition of a fee-for-service to a pay-for-performance system will affect the healthcare system drastically, and in different ways for many different hospitals. For instance, while the penalties may prove to be too costly for many hospitals to bear, some will succeed in reducing their readmission rates through improved quality care measurements. However, they will mostly consist of largely populated or rich hospitals in major cities. For cash poor or community hospitals which have fewer resources to invest in quality improvements, a loss in Medicaid reimbursement seems inevitable. As a result, there is the fear of a further financial gap between well to do hospitals and struggling local hospitals in the near future. In addition, as Medicare penalties and bonuses continues on in the near future, the percentage of bonuses dedicated towards patient satisfaction should decrease. While patient satisfaction is essential in a patient's recovery from their illness as well as a better establishment between them and their healthcare professionals, it doesn't define itself as a quality measure for which hospitals base their financial support from. In many hospitals, there are patients who provide the bulk of admission rates simply due to noncompliance, or the inability to afford the medications prescribed for them. In addition, patient dissatisfaction may arise for personal reasons even if a patient was fully recovered or treated. Since today's medicine is practiced more through evidence based rather

than through trial and error, quality measures should be based on how well a hospital follows protocols and guidelines.

Medicare Drug Discounts

Another major aspect of this title began in January 2011, when the PPACA required that drug manufacturers wishing to have their drugs covered under Medicare's Part D program participate in a discount program which requires them to provide a 50 percent discount on the price that Part D plan sponsors negotiate for brand name drugs when a beneficiary reaches the coverage gap.¹⁴ A benefit created through this negotiation with drug manufacturers is the ability to close the Medicare "donut hole" without having to raise prescription drug plan Part D premiums by much. The donut hole is a coverage gap that people with Medicare, almost one in every four elderly, commonly hits when a certain amount is spent on their drugs to which Medicare was no longer able to cover for them. At times, this led to serious financial challenges, in which resulted in many Medicare patients having to choose between money for everyday living or for their medications for the rest of the year. As a result, beginning 2011, any patients enrolled in a Medicare Prescription Drug Plan will receive a 50% discount on covered brand name drugs they need while in the donut hole.¹⁴ Over time, the discount will increase for both brand names and generics until the gap is closed in 2020. Expectedly, while this benefits almost any Medicare patients who have had financial troubles when they have reached their donut holes, this will impact pharmacies greatly, more so in the later years. With the discount increasing as the years go on, more prescriptions are expected to be refilled for this group of patients, therefore increasing pharmacy workload. However, this will also prove beneficial to an increased usage of mail order pharmacies in the future. With the advantages of convenience, time and cost savings as well as customized service, an increased introduction of retail chains and their mail order pharmacies may attract more Medicare patients who can save having to drive to a local pharmacy in order to get their regular prescriptions filled.

Medicare Preventive Services

Clinical preventative services, such as routine disease screenings and scheduled immunizations, are key to reducing disability and improving the nation's health. Many of these services can both prevent and early detect illnesses and diseases, leading to more treatable stages (cancer), preventing or delaying disabilities, and reducing future medical care costs. As a result, in this title the PPACA requires various preventive services to be fully covered without your having to pay a copayment to your provider. Preventative services range from Type 2 diabetes screening for all adults,

cervical cancer screenings for women, as well as immunization vaccines for children from birth to the age of 18.⁷ Since the health care reform, over 45 million women have received free mammograms and pap smears.⁷ Despite the establishment of free preventative services from the PPACA, public awareness of these services must be increased. As a result, this role can be a huge impact for pharmacists in the future. With a recent increased role for a pharmacist in providing vaccinations and immunizations, pharmacists across the country can contribute greatly to this through the educating of our patients of the various preventative care available. Furthermore, with the emergence of medication therapy management services (MTM) in which pharmacists can now provide, many of these preventative cares such as diet counseling, blood pressure, and obesity screenings may soon be done simply at your local retail pharmacy. With the ability to provide a free service at a convenient location, this aspect of the PPACA can save millions of dollars for the healthcare system down the line.

Conclusion

While there are many more aspects to the Patient Protection and Affordable Care Act, these key features discussed will impact the United States healthcare system the most in the near future. Health care reform, in its entirety, aims to shift our healthcare system in many ways. Some changes include a transition from fee-for-service to a pay for performance system, as well as from state based healthcare to a more national; governmental assisted one. In the end, the PPACA will not prove to be beneficial for everyone involved. Small businesses are expected to continue cutting corners in order to not pay the penalties that the health care reform demands, while community and local hospitals will struggle in order to survive their penalties if their readmission rates are not lowered. As a result, employment is expected to decrease in those areas. However, if the ultimate goal of the PPACA is satisfied, which is to increase access to affordable insurance coverage while working towards structural changes to keep future health care costs under control, then this author sees a greater benefit to risk ratio at the end of the tunnel. If health care reform fails to trim the health care budget in the next decades, then one must remind ourselves the state that our country's healthcare system was in before reform was enacted: while the United States spends more on health care per capita than any other nation in this world, our healthcare system was ranked 37th by the World Health Organization in 2000.¹⁵ (W.H.O declined to rank countries in the World Health Report in 2010) Despite any imperfections that health care reform may have, it is still a step towards more equitable healthcare in this country.

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