

The Affordable Care Act: **A Brief History, Assessment,** **and Future Challenges**

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This supplemental chapter was written by David R. Payne and edited by Anthony R. Kovner, PhD, and James R. Knickman, PhD.

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Many significant changes have occurred since the Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010. From provisions implemented shortly after passage of the law, such as offering of insurance plans to those with preexisting conditions and extending adult dependent coverage to age 26, to a Supreme Court battle over the law to the opening of the health care exchanges and efforts to defund or delay the law by opponents, the progress of health care reform in the United States has been lively, dramatic, and often contentious. The purpose of this chapter is to provide you with an updated, as of February 2015, summary of the historical context of the law, major milestones related to its implementation, and an overview of its many provisions, to build on the summary of key provisions of the law that is included in the 11th edition of this book. Finally, we consider the future of the health care reform law and questions that we need to ask to assess its effectiveness.

■ The Historical Context That Led to the ACA

Before considering the law itself, we should briefly review the status of the U.S. health care system prior to enactment of the ACA so that we can have a better understanding of the factors that led to the ACA.

GOVERNMENT INVOLVEMENT IN HEALTH CARE PRIOR TO THE ACA

Although more than half of Americans have health care coverage through private employment-based insurance plans, millions more currently depend on government-sponsored programs for this coverage. From Medicare and Medicaid, which were established by the Social Security Amendments of 1965, to the State Children's Health Insurance Program (SCHIP or CHIP), which was established in the Balanced Budget Act of 1997, to provision of health care to active duty military personnel via the U.S. Department of Defense Military Health System (MHS) and to veterans via the Veterans Health Administration (VHA), government programs have covered millions of Americans who might not have otherwise been covered. According to a report by the U.S. Census Bureau, in addition to the approximately 170.9 million (54.9%) Americans covered by employment-based health insurance in 2012, 50.9 million (16.4%) were covered by Medicaid and 48.9 million (15.2%) were covered by Medicare (DeNavas-Walt, Proctor, & Smith, 2013, p. 22).

A PROFILE OF THE UNINSURED

In spite of this progress, however, some 48 million people were estimated to have had no insurance coverage of any kind for the entire calendar year 2012, according to this same report.

Regarding racial demographics, Hispanics and, to a lesser degree, Blacks and Asians are disproportionately more likely to be uninsured than are White Americans. When age is taken into account, those aged 19 to 34 years were more likely to be insured than those in any of the other age categories. In terms of citizenship, 38.4 million of the uninsured were either native born or naturalized citizens, whereas 9.5 million (about 20% of the uninsured) were not citizens. Thus, the debate

over immigration reform intersects with that over health care reform, with conservatives disputing the inclusion of illegal immigrants among the number of the uninsured.

There are also disparities based on region of the country. Those living in the South had the highest percentage of uninsured when compared with their counterparts in the general population, followed by those living in the West, those in the Midwest, and those in the Northeast. Not surprisingly, disparities in insurance coverage were also based on household income, with nearly a quarter of those with a household income of less than \$25,000 not having insurance.

THE COST CRISIS IN AMERICAN HEALTH CARE

Now that we have a grasp of who the uninsured are, the next question is, why are they uninsured? According to the Kaiser Family Foundation, the primary reason is the high cost of health insurance (Kaiser Commission on Medicaid and the Uninsured, 2013). Other factors related to lack of insurance are as follows:

- Loss of employment and thus employment-sponsored health insurance
- Ineligibility for Medicaid
- Inability to qualify for private insurance due to a preexisting condition
- Inability to afford private insurance
- Inability to afford the employee's share of employment-sponsored insurance
- An employer who does not offer health insurance coverage

GOALS OF THE ACA

Considering the facts presented above, it is not surprising that many have called for reform of our health care system for decades. It is in response to these significant flaws in the system that the ACA was conceived, drafted, debated, passed, and signed into law and is being implemented. Four key goals of the ACA, as described on the Whitehouse.gov website (Health reform: About the new law, 2013), are as follows:

1. Establish consumer rights and protections
 - a. Elimination of discrimination related to preexisting conditions
 - b. Elimination of lifetime maximum dollar limits
 - c. Prevention of dropping of members' coverage due to errors on application
2. Provide more affordable coverage
 - a. Requirement that at least 80% of premiums be spent on medical care
 - b. Limits on rate increases
 - c. Tax credits for small businesses that offer health insurance to employees
3. Ensure better access to care
 - a. Requirement that insurers cover preventive services
 - b. Continuation of coverage of young adults on their parents' plans until age 26
 - c. Establishment of insurance exchanges, where individuals can find affordable health coverage

4 Affordable Care Act Supplement

4. Strengthen Medicare

- a. Lower the costs of prescription drugs for Medicare enrollees
- b. Expansion of preventive services, such as flu shots, diabetes screenings, and annual wellness visits, free of charge
- c. Elimination of fraud via tougher screening procedures, stiffer penalties, and technological advancements

■ The Political and Legislative Process That Produced the ACA

Now that we have an understanding of the historical context that led to the ACA, let us consider the political and legislative process that produced this law.

OBAMA'S POLITICAL MANDATE

Health care reform was a major plank in Obama's 2008 presidential campaign. Many of the features of the current law were included in Obama's health care reform proposal, including a requirement for all children to have health insurance, an expansion of Medicaid and SCHIP, premium subsidies to both individuals and employers, establishment of health insurance exchanges, elimination of discrimination against those with preexisting conditions, and extension of health coverage of dependents by their parents' policies up to age 25 (Kaiser Family Foundation, 2008).

Therefore, many of Obama's supporters viewed his decisive victory in the 2008 election as a mandate, or authorization, to act, particularly in regard to his health care reform agenda (Ververs, 2009). Still riding on the momentum of his recent election win, Obama wasted no time in bringing health care reform to the fore of the nation's political conscience. In his address to the joint session of Congress on February 24, 2009, little more than a month after his inauguration, Obama bemoaned the rapidly rising costs of health care for individuals and businesses alike and the devastating effects on the many families who lose health insurance every year. He touted the CHIP Reauthorization Act, which he had just signed into law weeks before, and committed to "bringing together businesses and workers, doctors and health care providers, Democrats and Republicans to begin work on [health care reform] next week" (Address to Joint Session of Congress, 2009). He admitted that this process would be "hard" but declared, "Health care reform cannot wait, it must not wait, and it will not wait another year."

OPPOSITION TO OBAMACARE

Ideological opposition to significant government involvement in health care and in health care reform is deep-rooted and dates back at least 60 years, when Harry Truman proposed national health insurance as part of his Fair Deal plan, as noted in Chapter 3 of the textbook. At that time, doctors, businessmen, and others resisted this liberal effort, decrying it as socialistic and expressing fears over the effects of increased government regulation on the health care system in general and on their personal livelihoods. This same strain of conservative opposition has continued to the present and must be understood for one to grasp why the debate over health care reform has been so passionate.

At the core of this debate are fundamentally different perspectives on the proper role of government. Liberals—typically Democrats—have championed the concept of the government playing a

primary role in establishing and managing large government-funded social programs, including Social Security, Medicare, Medicaid, welfare, and health coverage, which benefit all members of society. They emphasize the value of compassion and promote efforts by the government to meet the needs of all citizens, especially the poorest and most vulnerable in society. Conversely, conservatives—typically Republicans—fear that a large federal government will abuse such power and believe that the private sector should be the primary player in such efforts. They tout the values of individual liberty and personal responsibility and favor a more limited, free-market approach to health care and other critical services needed by people. Moreover, conservatives' concern over the mounting national debt and annual deficits and skepticism that the ACA will be able to reduce these have only stoked their opposition to the reform effort.

Given these diametrically opposed stances, it is not surprising that debate over health care reform has been so contentious through the decades. It was for this reason that Obama rightly acknowledged the difficulty of pursuing reform.

POWER STRUGGLE IN THE HOUSE AND SENATE AND THE PASSAGE OF THE ACA

On Obama's inauguration, Democrats held majorities in both the House of Representatives and the Senate, giving them a huge advantage in the struggle over health care reform that was to unfold. By the summer of 2009, committees in both the House and Senate were meeting to discuss possible approaches to health care reform.

In the Senate, Max Baucus (D-MT), Chairman of the Senate Finance Committee, and Chuck Grassley (R-IA), Ranking Member, held several committee roundtables on health care reform with health policy and industry experts (The United States Senate Committee on Finance, 2010). Later, they held a series of bipartisan meetings over 3 months that explored the development of a health care reform law. The result of these efforts was the America's Healthy Future Act, approved by the Finance Committee on October 13, 2009. This bill would become the basis for the ACA, which was debated on the Senate floor and brought to a vote in that chamber on December 24, 2009. Leading in to this vote, the Democrats held a 60-vote supermajority in the Senate, including 58 Democrats and two Independents who were voting with them on health reform. The Republicans, who were united against it, held only 40 seats. This meant that the Senate Democrats, if united, could pass the ACA without the Republicans having the opportunity to filibuster, or block, the vote. Therefore, the ACA was passed by the Senate with a 60-39 vote (one Republican did not vote; The United States Senate Committee on Finance, 2010).

In the meantime, the House of Representatives had drafted its own bill, called the Affordable Health Care for America Act, which it passed on a 220-215 vote on November 7, 2009, with all but 39 Democrats voting for it and all but one Republican voting against it (Timeline, 2010). This bill was then sent to the Senate to be voted on, while that chamber was working on its own version. Democrats hoped to merge the two bills and then to bring it to a vote in both chambers.

However, the special election of Scott Brown (R-MA) to the Senate to fill Edward Kennedy's (D-MA) seat upset the balance of power in the Senate and resulted in Democrats no longer having a supermajority (Timeline, 2010). This meant that any merged, revised bill, which would have to be voted on by both houses, would likely be filibustered in the Senate by the Republicans. In an effort to garner bipartisan support and salvage the effort for reform, Obama presented his own health care plan, based heavily on the Senate bill. On February 25, 2010, the President hosted a bipartisan

6 Affordable Care Act Supplement

health care summit, which was characterized by strong objections on the part of Republicans to Obama's proposal (Timeline, 2010).

Ultimately, to avoid facing a filibuster in the Senate, it was decided that the House would vote on the Senate bill, and that any changes that House Democrats wanted to the bill would be included in a separate "reconciliation" bill, which would not be subject to filibuster and could thus be passed in the Senate by a simple majority. Therefore, the House passed the Senate bill with a 219-212 vote on March 21, 2010. The amendment bill, The Health Care and Education Reconciliation Act, was passed by the House on March 21 and by the Senate, via the special reconciliation process, which is reserved for budgetary issues, on March 25. The ACA was signed into law by Obama on March 23, 2010; the amendment was signed by Obama on March 30.

THE IMMEDIATE AFTERMATH OF PASSAGE OF THE ACA

Due to the highly divisive nature of the debate over health care reform, the completely partisan votes and lack of cooperation between the parties, and complex, controversial parliamentary maneuvering required to pass the law, both the process of passage and the end product of the law were far from ideal. Even among the Democrats, there were divisions over whether the reform should include more elements of a single-payer system. Republicans, of course, were strongly opposed to many aspects of the law and felt disenfranchised from the process. In particular, they objected to the individual mandate, which is the provision of the law that requires all individuals to have health insurance or face paying a fine. Many argued that this measure was unconstitutional and an infringement on personal liberties. They also expressed concern over the effect that the law, with its government-sponsored exchanges, would have on the private health insurance industry and the ability of the government to efficiently and successfully manage such a large program.

Furthermore, these polarized views of the law also reflect the views of the nation as a whole. Although the American public has generally supported the idea of health care reform, the ACA itself has lacked a majority support in many polls. A Gallup poll conducted between November 6 and 28, 2014, indicated that 37% of those polled were in favor of the law and 56% were opposed (McCarthy, 2014). A poll by the Kaiser Family Foundation tracking public opinion of the ACA following the midterm elections in November 2014, in which Republicans increased their majority in the House of Representatives and took control of the Senate, indicates that 32% of those polled would like Congress to repeal the law entirely, 14% would like the law to just be pared down, and 23% would like Congress to expand the law (DiJulio, Firth, & Brodie, 2015).

■ Basic Provisions of the Law

In this section, we consider the specific provisions of the ACA. Note that this content is taken from the Kaiser Family Foundation's Summary of the Affordable Care Act. The provisions may be divided into three categories: insurance coverage, insurance reform, and measures intended to reduce costs and improve quality of the health care system as a whole.

INSURANCE COVERAGE

As noted, one of the key goals of the ACA was to expand health care coverage for millions of Americans. Several key measures of the law are designed to help achieve that goal. These include

Medicaid and CHIP expansion, need-based subsidies for individuals, individual and business mandates for coverage, and insurance exchanges.

Medicaid and CHIP Expansion

Besides establishing new measures to increase health care coverage for all Americans, the ACA also expands the existing health care entitlements—Medicaid and CHIP. Specifically, Medicaid is being expanded to include all people under the age of 65 who are not eligible for Medicare and whose incomes are 133% or less of the federal poverty level. Those who are newly eligible for Medicaid will be offered a benefit package through the exchanges. The federal government will subsidize the cost of coverage for these newly eligible participants by providing 100% funding to the states in the first year and then gradually reducing the funding over the next 6 years until a level of 90% is reached, which will be sustained indefinitely. However, the Supreme Court hearing on the ACA in 2012 rendered the expansion of Medicare optional for the states, so results will likely vary greatly from state to state (Kaiser Family Foundation, 2013a).

The ACA also requires states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019 and continue funding for CHIP through 2015. It allows states to offer CHIP coverage to children of state employees and, in 2015, will increase the maximum match rate for federal funding to states (Kaiser Family Foundation, 2013a).

Subsidies to Individuals and Businesses

Other measures in the ACA include subsidies for both individuals and businesses to make health coverage more affordable. Beginning January 1, 2014, premium credits for individuals are need-based and graduated according to income as a percentage of the federal poverty level. Table 1 shows the amount of premium credit available as a percentage of income for various income levels. Moreover, the credits that are subject to increase in subsequent years cover increases in premiums relative to income. In addition to premium credits, the ACA also offers cost-sharing subsidies to individuals, again based on income level. Table 2 shows the percentage of medical costs covered by the plan for each income level. Both types of subsidy require verification of income and citizenship status. Moreover, the subsidies may not be used to purchase abortion coverage, except when the life of the woman is in danger or in the case of rape or incest (Kaiser Family Foundation, 2013a).

TABLE 1 PREMIUM CREDITS AVAILABLE FOR VARIOUS INCOME LEVELS

Income as a Percentage of Federal Poverty Level	Amount of Premium Credit Available, as a Percentage of Income
Up to 133%	2%
133% to 150%	3% to 4%
150% to 200%	4% to 6.3%
200% to 250%	6.3% to 8.05%
250% to 300%	8.05% to 9.5%
300% to 400%	9.5%

Source: Kaiser Family Foundation (2013a).

8 Affordable Care Act Supplement

TABLE 2 COST-SHARING SUBSIDIES AVAILABLE FOR VARIOUS INCOME LEVELS

Income as a Percentage of Federal Poverty Level	Percentage of Medical Costs Covered by Plan
100% to 150%	94%
150% to 200%	87%
200% to 250%	73%
250% to 400%	70%

Source: Kaiser Family Foundation (2013a).

The ACA also offers premium subsidies to employers in the form of tax credits for small businesses and reinsurance programs. The tax credit is offered to businesses that employ 25 or fewer employees, that pay average annual wages of less than \$50,000, and that provide health insurance to their employees. In the first phase of this program—2010 to 2013—the eligible business will receive a tax credit of up to 35% of the employer’s contribution toward the employee’s health insurance premium if the employer contributes at least 50% of the total premium cost. Companies with 10 or fewer employees and average annual wages of less than \$25,000 that provide health insurance for employees will receive a credit for the full amount that the employer contributes to cost of the employee’s premium. In the second phase—2014 and later—businesses with 25 or fewer employees and average annual wages of less than \$50,000 will receive a tax credit of up to 50% of the employer contribution toward employee premiums, and those with 10 or fewer employees and average annual wages of less than \$25,000 will receive a tax credit for the full amount of the employer contribution. The ACA also establishes a temporary reinsurance program, effective for 90 days following enactment of the law through January 1, 2014, that reimburses employers or insurers for 80% of claims between \$15,000 and \$90,000 of retirees who are not eligible for Medicare (Kaiser Family Foundation, 2013a).

The Mandate for Coverage: Individuals and Employers

Perhaps one of the best known aspects of the ACA—and one of the most controversial—is the individual mandate for coverage. This measure requires U.S. citizens and legal residents to have qualifying health coverage or to pay a tax penalty of the greater of \$695 or 2.5% of taxable income, up to a maximum amount of \$2,085. The first 2 years, however, the penalty is phased in, such that in 2014, the flat fee is \$95 and the taxable income rate is 1.0%, and in 2015, the flat fee is \$325 and the taxable income rate is 2.0%. After 2016, the penalty is subject to being increased in proportion to the cost of living. Exemptions will be granted in certain circumstances, such as financial hardship or lack of coverage for less than 3 months (Kaiser Family Foundation, 2013a).

A mandate for employers to provide health coverage to employees is also included in the ACA. It stipulates that employers with 50 or more full-time employees, at least one of whom receives a premium tax credit, must offer health coverage to their employees or pay a fee of \$2,000 per full-time employee. Those with fewer than 50 full-time employees are exempt from this measure. Employers with more than 200 employees must automatically enroll employees into insurance plans offered by the employer, but employees may opt out of coverage (Kaiser Family Foundation, 2013a).

Insurance Exchanges

Another well-known feature of the ACA is the health insurance exchanges. The exchanges are state-based marketplaces operated by a governmental agency or non-profit organization where individuals and businesses can purchase qualified health coverage. The idea behind these organizations is to provide affordable alternatives to private insurers. Participants in such exchanges must be U.S. citizens or legal immigrants and not be incarcerated. The law requires each exchange to offer at least two multi-state plans, at least one of which must be offered by a non-profit entity and at least one of which must not provide coverage for abortions. A related aspect of the law is the establishment of the Consumer Operated and Oriented Plan (CO-OP) program, which seeks to encourage the creation of non-profit, member-run health insurance companies (Kaiser Family Foundation, 2013a).

Each exchange is also required to offer five benefit levels, as described in Table 3, with each level covering a different percentage of medical costs, from 60% in the “Bronze” plan to 90% in the “Platinum” plan. The fifth plan is a catastrophic plan, which only covers costs that exceed a high deductible (Kaiser Family Foundation, 2013a).

Moreover, the out-of-pocket limits are reduced in a graduated fashion depending on income level for those with incomes up to 400% of the federal poverty level, to further protect individuals and families (Table 4).

All exchanges are required to meet stringent administrative, financial, and coverage standards established in the ACA. One measure, which was included to garner support among pro-life lawmakers during passage of the ACA, is that states be permitted to prohibit plans in the exchange that offer coverage for abortions and that no federal subsidies be used to pay for abortion coverage (Kaiser Family Foundation, 2013a).

INSURANCE REFORM

In addition to the establishment of the exchanges, the ACA also includes many measures intended to reform the private insurance sector, making it easier for people to both obtain and keep quality health coverage.

TABLE 3 HEALTH CARE EXCHANGE BENEFIT LEVELS

Name of Plan	Type of Benefits Included	Percentage of Benefit Costs Covered by Plan Before Out-of-Pocket Limit Is Met	Out-of-Pocket Limits
Bronze	Essential	60%	HSA levels***
Silver	Essential	70%	HSA levels
Gold	Essential	80%	HSA levels
Platinum	Essential	90%	HSA levels
Catastrophic*	Catastrophic	0%**	HSA levels

*The catastrophic plan is available only to those up to age 30 years or those who are exempt from the individual mandate and on the individual market.

**Exceptions include prevention benefits and coverage for three primary care visits, which are exempt from the deductible.

***The Health Savings Account (HSA) out-of-pocket limits were \$5,950 for individuals and \$11,900 for families in 2010.

Source: Kaiser Family Foundation (2013a).

10 Affordable Care Act Supplement

TABLE 4 REDUCED OUT-OF-POCKET LIMITS FOR THOSE WITH INCOMES UP TO 400% OF FPL

Income Level	Out-of-Pocket Limits
100% to 200% of FPL	Onethird of the HSA limits (\$1,983/individual and \$3,967/family)
200% to 300% of FPL	Onehalf of the HSA limits (\$2,975/individual and \$5,950/family)
300% to 400% of FPL	Twothirds of the HSA limits (\$3,987/individual and \$7,973/family)

FPL, federal poverty level; HSA, Health Savings Account.
Source: Kaiser Family Foundation (2013a).

Guaranteed Issue and Preexisting Conditions

One of the biggest reforms pertains to guaranteed issue and not excluding those with preexisting conditions. Guaranteed issue means that the insurer must offer health coverage to an individual regardless of that individual's current health status. Also, the insurer may not exclude specific preexisting conditions from being covered. These measures are designed to prevent the type of discrimination prevalent before enactment of the ACA, whereby many could not obtain health coverage due to preexisting conditions.

Coverage of Dependents

Another highly touted feature of the ACA is that it requires insurers to provide coverage of dependents up to the age of 26 years.

No Lifetime Limits or Rescinding of Coverage

Before passage of the ACA, insurers commonly included lifetime limits on the amount spent to cover medical costs per individual. Many with chronic diseases requiring expensive treatment or who experienced extended hospital stays due to severe injuries exceeded their lifetime limits and were no longer covered by their insurance plan. A provision in the ACA, however, prohibits the inclusion of lifetime limits on insurance plans or the rescinding of coverage, except in cases of fraud.

Required Benefit Categories

Under the ACA, all insurance plans, whether offered through an exchange or through a private insurer, must correspond to one of the four benefit categories described previously (Bronze, Silver, Gold, or Platinum). This measure is intended to ensure consistency and quality of coverage in plans across all insurers (Kaiser Family Foundation, 2013a).

Limits to Deductibles and Waiting Periods

Deductibles for health plans in the small group market are limited to \$2,000 for individuals and \$4,000 for families. Waiting periods, a common feature among pre-ACA insurance plans, required newly insured individuals to wait a set amount of time before any or some of the coverage went into effect. These periods commonly extended to a year or more. The ACA limits such periods to 90 days (Kaiser Family Foundation, 2013a).

Medical Loss Ratio and Premium Rate Reviews

In addition to the clinical services that insurers pay for, they also typically spend significant amounts on administrative, marketing, and other costs. To help ensure that the bulk of consumers'

premiums is actually going toward their care and not to non-clinical costs, the ACA includes a requirement that at least 85% of the consumer's premium for the large group market and 80% for the individual and small group markets be spent on clinical services and quality-related costs, with rebates being sent to consumers equal to the amount under these percentages, if applicable. Moreover, the law requires a stringent review of processes for determining increases in premium rates and detailed plans justifying any increases. This measure is intended to curb the steep annual premium increases that have become prevalent in insurance plans (Kaiser Family Foundation, 2013a).

Transparency and Consumer Protections

In an effort to increase the transparency with which insurers operate, the ACA requires insurers to post health coverage options on an internet website and to develop a standard format for presenting information on coverage options. Insurers are also to adhere to standards related to the presentation of benefits and coverage established by the ACA.

Health Care Choice Compacts and National Plans

Before the ACA, insurers were often limited by state regulations from competing with insurers in other states. The ACA allows states to form health care choice compacts and insurers to sell policies in other states.

Grandfathering of Existing Plans

To protect those who had plans that were in place at the time the ACA was passed, the law “grandfathers” in such plans, not requiring them to meet the same criteria as new plans. However, grandfathered plans are still required to extend dependent coverage to age 26, eliminate rescissions of coverage, eliminate lifetime and annual limits on coverage, and eliminate preexisting condition exclusions for children and waiting periods of greater than 90 days (Kaiser Family Foundation, 2013a).

HEALTH CARE SYSTEM COST REDUCTIONS AND QUALITY IMPROVEMENT

Beyond the establishment of the exchanges and reform of the private insurance sector, the ACA also seeks to implement measures that contain costs and improve quality across the entire health care system.

Center for Medicare and Medicaid Innovation

One such measure is the establishment of the Center for Medicare & Medicaid Innovation (CMMI), within the Centers for Medicare & Medicaid Services, the governmental agency that manages these existing health insurance programs. This center is responsible for developing new payment and service delivery models, organized into seven categories (Centers for Medicare & Medicaid Services, 2013a):

- Accountable care
- Bundled payments for care improvement
- Primary care transformation
- Initiatives focused on the Medicaid and CHIP population

12 Affordable Care Act Supplement

- Initiatives focused on Medicare–Medicaid enrollees
- Initiatives to speed up the adoption of best practices
- Initiatives to accelerate the development and testing of new payment and service delivery models

This organization seeks to cut costs in health care by improving the efficiency with which services are provided while maintaining or improving quality. The models that it produces could be used in Medicare, Medicaid, and CHIP.

Accountable Care Organizations

Another measure is the funding and promotion of accountable care organizations (ACOs; see Chapter 9 in the textbook), which are systems of providers in local settings who take different types of capitated payments to coordinate all of the care required by people in the covered group and be held accountable for that population of patients, similar to health maintenance organizations (HMOs). The idea behind these organizations is that they will be motivated to invest in preventive and wellness care to help keep their patients healthy and thus reduce expenditures on costly treatments of health conditions. The ACA now allows such organizations to share in the cost savings they realize for the Medicare program. To qualify as an ACO, an organization must “agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care” (Kaiser Family Foundation, 2013a).

Health Homes

Yet another measure of the ACA to contain costs and improve quality is an optional Medicaid State Plan benefit that allows states to establish “health homes” for the coordinated care of Medicaid patients with chronic conditions (Centers for Medicare & Medicaid Services, 2013b). A health home is a designated provider or team of health care professionals who are accountable for providing care for a qualified Medicaid patient. To qualify, the patient must meet the following criteria:

- Have two or more chronic conditions
- Have one chronic condition and be at risk for another
- Have one serious and persistent mental health condition

Services that may be provided by a health home include the following:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care or follow-up
- Patient and family support
- Referral to community and social support services

The health home providers are required to report certain data regarding quality of services to the state. The states then receive an enhanced 90% federal reimbursement for certain qualified health home services, up to eight total quarters for each enrollee (Centers for Medicare & Medicaid Services, 2013b).

Expansion of Primary Care

As mentioned, one of the significant concerns regarding the U.S. health care system in recent years has been the lack of enough primary care providers to meet the demand for care, in part due to the greater pay that the medical specialties offer. This concern only becomes more acute with the implementation of the ACA, as the demand for primary care could soar as millions of previously uninsured Americans enroll in insurance plans and begin to seek care. Thus, included in the ACA are measures that seek to expand primary care services, particularly in Medicare and Medicaid. For example, Medicaid payments (both for fee-for-service and for managed care) for primary care services provided by primary care providers are increased to 100% of the Medicare payment rates for 2013 and 2014. Moreover, primary care physicians in Medicare will receive a 10% bonus payment from 2011 through 2015 (Kaiser Family Foundation, 2013a).

Other Measures

These are just a few of the many measures included in the ACA to reduce costs and improve quality. Other measures include the following (Kaiser Family Foundation, 2013a):

- Simplification of health insurance administration by adopting one set of rules for eligibility verification, claims status, and payment and remittance
- Strategic reductions in Medicare and Medicaid expenditures
- Increase the approval of generic versions of drugs by the Food and Drug Administration (FDA)
- Reduce waste, fraud, and abuse in Medicare and Medicaid through provider screening, greater oversight of providers and suppliers, development of a federal database to share data across programs, penalties for false claims, and other measures
- Promotion of comparative effectiveness research by establishment of the Patient-Centered Outcomes Research Institute
- Grants to develop alternatives to current tort litigations
- Exploration of bundling all payments for one episode of care to improve quality of care

■ The Supreme Court Battle Over the ACA

After the individual mandate of the ACA was found to be unconstitutional by lower courts, the case was brought before the U.S. Supreme Court as the *National Federation of Independent Business v. Sebelius*. The Court heard the case over 3 days, March 26 to March 28, 2012. As before, the key issue in the case was the constitutionality of the individual mandate. This issue was paramount because the individual mandate is critical to the viability of the entire law, as it would cause healthy people to purchase health insurance and not just the sick, thereby keeping insurance premiums affordable for all. Opponents of the law had long argued that it was not within the constitutional authority granted the federal government to force citizens to purchase any product or service. Proponents of the law had argued that the penalty imposed by the individual mandate could be characterized as a tax, which would fall within the constitutional authority of Congress to levy. On this issue, a 5-4 majority of justices ruled that the individual mandate was constitutional because it could be reasonably characterized as a tax, with conservative Chief Justice John G. Roberts Jr. siding with the four more liberal members of the court (Liptak, 2012). In a separate vote regarding Congress's power to regulate interstate commerce, which was at the core of conservatives' opposition to the individual

14 Affordable Care Act Supplement

mandate, however, a 5-4 majority ruled that Congress did not possess such power. Finally, the court also ruled in a 7-2 majority that the Congress could not coerce states into expanding the Medicaid program, which is co-administrated by the states and the federal government (Liptak, 2012).

The rulings by the Supreme Court were hailed as a major victory by President Obama and other supporters of the ACA, as they eliminated one of the greatest challenges to date to the law. Opponents of the law, naturally, were frustrated with the decision, as it represented a dead end to future legal challenges pertaining to the constitutionality of the law.

Other aspects of the law, however, continue to be scrutinized, and the Supreme Court is expected to hear the case of *King v. Burwell* in March regarding whether people in all 50 states should be eligible for financial aid from the federal government to purchase insurance, even if the person's state of residence does not operate its own health care marketplace (DiJulio, Firth, & Brodie, 2015).

■ Implementation Process

In this section, we examine how key provisions of the law have been implemented to date.

GOVERNMENT SHUTDOWN AND CONTINUED REPUBLICAN OPPOSITION

As the federal government approached an October 1, 2013, deadline for passing a bill to fund the government, Republicans in Congress sought to take advantage of the threatened shutdown of the government by attaching to various iterations of a funding bill a series of provisions to defund, delay, or otherwise hinder the implementation of the ACA. Republican Senator Ted Cruz staged a 21-hour filibuster on the floor of the Senate to voice opposition to the health reform law. With Congress failing to reach an agreement, the government shutdown commenced on October 1, the same day that the ACA exchanges opened, and Republicans continued to fight against the ongoing implementation of the health law in the coming weeks.

All of the bills with anti-ACA measures were rejected in the Senate by the Democrats, however, who held the majority in that chamber. Ultimately, with mounting public frustration with the shutdown and the even more serious implications of a failure to raise the federal debt limit, a deadline for which was also looming, Republicans conceded and sent a "clean" funding bill to the Senate. The bill was passed on October 16 and was signed into law by Obama hours later, ending the shutdown. Thus, the ACA weathered yet another attack by its opponents.

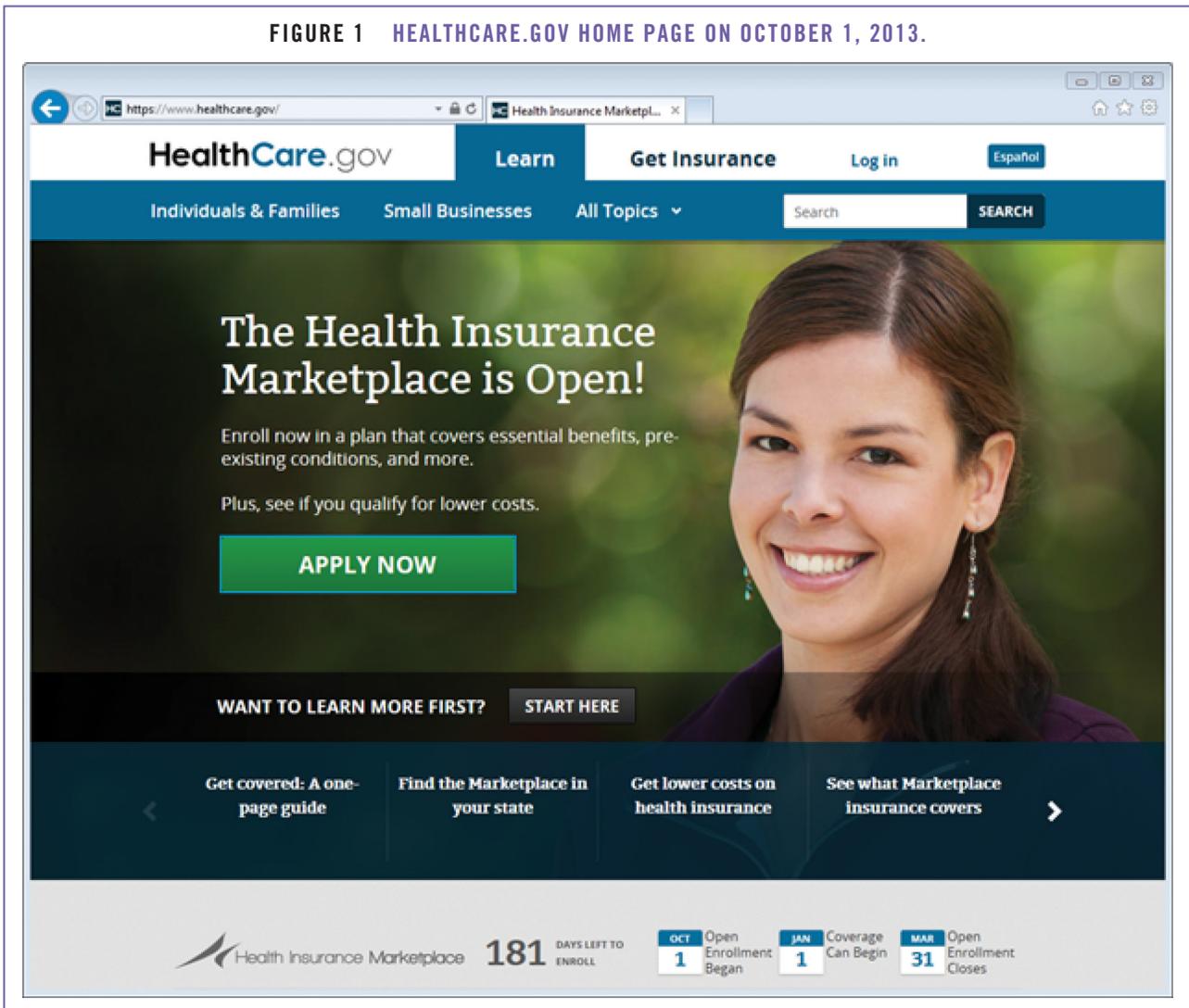
More recently, the U.S. House passed a bill that would change the requirement that employers with 100 or more employees must offer health insurance coverage to all employees who work 30 hours or more, making it so that only those working 40 hours or more would be eligible for coverage (DiJulio, Firth, & Brodie, 2015). The Senate is still deliberating on the matter. There is also discussion on repealing the medical device tax that is currently part of the law. With Republican majorities in both chambers of Congress now, such attempts to chip away at the law will likely continue.

LAUNCH OF THE EXCHANGES AND INITIAL PROBLEMS

One of the most visible aspects of the implementation of the ACA was the rollout of the state-based exchanges in late 2013. The initial open enrollment of these exchanges began on October 1, 2013, and ended on March 31, 2014. The exchanges went into effect on January 1, 2014 (Health reform: About the new law, 2013). Under the ACA, states had the option of setting up

and managing their own exchanges, or “Marketplaces,” or of using the federal government’s Marketplace at Healthcare.gov (Figure 1). Sixteen states and the District of Columbia opted to create their own exchanges, whereas all other states opted to use the federal exchange. For several months following the initial launch of Healthcare.gov and the Marketplace exchanges, multiple glitches plagued the website, rendering it difficult for many to apply for and obtain insurance plans through the exchanges. First, many encountered error messages when trying to complete an application or simply learn more about the plans available on the exchanges (Kliff, 2013). At first, administration sources claimed that it was due to the high volume of traffic on the website that problems were encountered, but it later became evident that the errors went much deeper than this. The system was also returning faulty data for many who had applied, rendering some as ineligible for some benefits of the program who should have been eligible and vice versa (Kliff, 2013). Moreover, the insurers offering plans through the exchanges reported receiving inaccurate data and duplicate applications.

FIGURE 1 HEALTHCARE.GOV HOME PAGE ON OCTOBER 1, 2013.



16 Affordable Care Act Supplement

The fault for the problems with the website appear to have been due to poor design by the federal contractors who were responsible for creating it, namely CGI Federal and QSSI (Kliff, 2013). It also became evident that inadequate testing of the website was done before it was launched, as acknowledged by officials in the Centers for Medicare & Medicaid Services (Somashkhar & Goldstein, 2013).

The second open enrollment period for the Marketplace began on November 15, 2014, and was set to end on February 15, 2015. Enrollment was much smoother this time, with far fewer problems reported by enrollees (Figure 2; Galewitz & Gorman, 2014).

An even more significant concern has been the growing number of people with individual coverage whose health care insurance plans have been canceled by insurers due to a lack of compliance with standards enforced by the ACA. It is now estimated that approximately 2.6 million people have lost coverage because of this noncompliance (Clemans-Cope & Anderson, 2014).

Another concern is the higher-than-expected premiums for many plans offered on the exchanges. Although rates vary greatly from state to state and some have reported finding lower

FIGURE 2 HEALTHCARE.GOV HOME PAGE ON FEBRUARY 9, 2015.

The screenshot shows the Healthcare.gov homepage with the following elements:

- Header:** Healthcare.gov logo, navigation tabs for "Individuals & Families" and "Small Businesses", "Log in" link, and "Español" language selector.
- Secondary Navigation:** "Get Coverage", "Keep or Change Your Plan", "Get Answers", and a search bar with a "SEARCH" button.
- Main Banner:** "Last chance: Enroll by February 15" with subtext "February 15 is your last chance to enroll in 2015 coverage. Get started now". It includes a "Select Your State" dropdown menu and a link: "Have a baby, adopt, get married, or lose coverage in 2015? See if your coverage can start sooner than usual."
- Enrollment Prompt:** "ENROLLED IN A 2015 PLAN? YOU CAN CHANGE UNTIL FEBRUARY 15" with a "LEARN HOW" button.
- Service Grid:** Four columns with icons and text: "\$ SEE PLANS & PRICES" (with "COMPARE HEALTH PLANS" button), "☰ TAX INFO & TOOLS" (with "GET ANSWERS & TOOLS" button), "A FIND LOCAL HELP" (with "SEARCH" button), and "📄 CONTACT US" (with "GO" button).
- Footer:** "Health Insurance Marketplace" logo on the left and "6 DAYS LEFT TO ENROLL" countdown on the right.

premium rates for plans on their state exchanges compared with plans available in the individual market, many others are finding higher rates and experiencing sticker shock when investigating plans available on the exchanges (Appleby, 2013). Moreover, the amount that the average person is paying toward health care expenses—including in premiums, deductibles, and copayments—has actually increased since passage of the ACA (Rosenthal, 2015).

As a result, perhaps, of the technological obstacles to accessing the website and of the premium rates, enrollment was far slower than anticipated during the initial enrollment. Although the pace increased as the March 31 deadline approached and despite initial reports from the administration of more than 8 million being enrolled, only 6.7 million were actually enrolled by the close (Luhby, 2014). With the second enrollment period ending on February 15, 2015, current estimates from the Department of Health and Human Services put the total number enrolled at approximately 12 million (Armour, 2015).

OTHER EARLY RESULTS OF IMPLEMENTATION

Despite the highly publicized problems with Healthcare.gov, there are some indications that other aspects of the ACA are bearing fruit. Most significantly, it is estimated that about 8 to 11 million people who had been uninsured gained coverage in 2014—about half of these through private insurance plans available on the online marketplaces and about half through new enrollment in Medicaid (Sanger-Katz, 2014a).

Moreover, there is some evidence that the ACA has contributed at least modestly to the slowing of the growth of health care spending in recent years. The rise in health care spending in the United States has slowed significantly through 2014 (Sanger-Katz, 2014b). However, this slowdown had begun before the passage of the law and is occurring worldwide, indicating that other factors are at work. Moreover, spending is expected to increase in the coming years, in part due to the recovering economy and the larger numbers of people being covered by health insurance due to implementation of the ACA. For instance, more than 428 provider groups have joined affordable care organizations since the passage of the ACA, and there are reports that such organizations are improving the quality of health care for patients (Gold, 2014).

The results of the ACA, however, are still unfolding and will become evident only as the program is gradually implemented in the coming years.

■ Early Assessment: What to Watch for in 2016 and Beyond

As the ACA continues to be implemented in the next few years, we should consider the following questions to assess its progress.

- **How effective are the exchanges?** Despite problems with the early roll-out of the Healthcare.gov website, enrollment numbers have progressed, and nearly 12 million have enrolled as of February 2015. Will enrollment continue to increase and meet expectations?
- **Do the young enroll?** As discussed, the main purpose of the individual mandate was to ensure that young, healthy people acquired health insurance as a result of the ACA and not just sick people. If enough younger people do not enroll, there will likely not be enough funds through premiums to support the program.

18 Affordable Care Act Supplement

- **What happens to premiums?** Again, if not enough healthy people enroll or if not enough people in general enroll, the result will be a spike in premiums to support the program. Moreover, the effect of implementation of the ACA on the premiums of private plans should also be monitored. Over 2 million people are estimated to have lost health care coverage due to plans not being compliant with the ACA. Will these trends continue?
- **Do more states accept Medicaid expansion dollars?** Despite the fact that the ACA contains many provisions that authorize the expansion of Medicaid, states are not obligated to accept federal funding for this purpose or to actually implement this expansion. In states that do not significantly expand Medicaid, many new enrollees may have trouble finding care.
- **Do system reforms get implemented?** The degree to which measures such as the development of more streamlined methods of payment and reimbursement, the formation of health homes and affordable care organizations, and the expansion of primary care services will all affect the costs of health care, the efficiency with which it is delivered, and the availability of basic care for all who need it.
- **Do costs of health care continue to inflate at reasonable rates?** The ACA contains various measures that seek to curb the rapid increase in health care costs, such as the requirement for insurers to develop stringent processes for reviewing and approving premium rate increases. Insurers' compliance with such regulations as well as the effectiveness of the Department of Health and Human Services in enforcing them will likely determine how rapidly health care costs continue to increase.
- **How does ACA play into the 2016 elections?** The political forces at play in the debate over health care reform have been described in detail. With Republicans now in control of both the House and the Senate, with the potential of gaining the White House in 2016, there is a much greater chance that the ACA could be repealed, defunded, delayed, or reduced in scope or force.

■ Conclusion

Despite the various government programs to expand health care coverage that have been implemented since the 1960s, nearly 50 million Americans remain uninsured and health care costs have risen at such rapid rates as to make even basic care unaffordable for many. The ACA was designed to address these problems. Its goals are to establish consumer rights and protections, provide more affordable coverage, ensure better access to care, and strengthen Medicare.

President Obama was elected to his first term with what many believe to be a mandate to pursue health care reform, as it was a major component of his campaign. Republicans and conservatives, however, strongly opposed the President's plan for reform and resisted the effort to pass legislation. However, with Democrats controlling the White House and both chambers of Congress, the ACA was eventually passed and signed into law in March of 2010. The law was passed along strict partisan lines, however, and was and remains politically controversial.

The ACA contains many provisions, which fall under four broad categories: Medicaid and CHIP expansion, need-based subsidies for individuals, individual and business mandates for coverage, and insurance exchanges. Some of these were implemented soon after the passage of the law, in 2010. Others have been implemented in the years since then, and a few will be implemented in the coming years.

Efforts to repeal, defund, delay, and otherwise weaken the ACA began immediately after it was passed and will likely continue in the coming years. A key victory for the law, however, was achieved when the Supreme Court upheld the constitutionality of the individual mandate and essentially provided a legal green light for its implementation.

Although there is evidence of cost containment and quality improvement benefits already from the first 5 years of implementation of the ACA, the roll-out of Healthcare.gov, the primary portal to the state-based health insurance exchanges, was highly problematic. It now appears that most of these technological glitches have been worked out, and the second year of enrollment has gone much more smoothly.

The ACA is still in its infancy in terms of implementation, and the jury is still out on how effective it will be in meeting its goals. Lack of enrollees or of healthy enrollees, unexpectedly high premiums for exchange-based plans, and political opposition could derail the program completely or weaken it. Alternatively, high enrollment numbers, effective implementation of cost containment and quality improvement programs, cooperation of states, and collaboration between political parties could firmly establish the ACA as a successful entitlement program, ensuring health care coverage to millions of Americans who would not otherwise have had it.

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