CHAPTER ONE

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

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Learning Objectives

- Understand the political circumstances leading to the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010
- Learn the major components of the ACA and the timetable for their implementation
- Examine the expected impacts of the ACA on major stakeholders in the U.S. health care system

The Patient Protection and Affordable Care Act of 2010 is the most significant piece of U.S. health legislation since the enactment of Medicare and Medicaid in 1965. The law is now more commonly known simply as the Affordable Care Act (ACA) and will be referred to throughout this book as the ACA. It has also been referred to pejoratively by opponents as Obamacare, at least until the 2012 presidential campaign, when President Obama embraced that label to describe the most significant legislative achievement of his first term. At the time of its enactment, the ACA was expected to extend health insurance coverage to thirty-two million uninsured U.S. citizens and permanent residents by 2016 (Congressional Budget Office [CBO], 2011), thus reducing the portion of uninsured legal residents from 17 percent to 5 percent.

How did this major piece of legislation get enacted after several failed attempts to expand health insurance to all Americans during the forty-five years between the enactment of Medicare and Medicaid in 1965 and the enactment of the ACA in 2010? And will the ACA finally achieve the goal of providing (nearly) universal access to health insurance in the United States while promoting higher quality care at an affordable and sustainable rate of growth in health care expenditures into the future? These are fundamental questions that will be explored throughout this book.

Since the first edition of this book was published in 1996, just a few short years after the failed effort of President Clinton to enact universal health insurance, the book's major purpose has been to discuss the fundamental challenges facing the U.S. health care system and to provide readers with both conceptual frameworks and the most current empirical evidence necessary to formulate effective strategies for innovation. At the time of this writing, the United States stands poised to undertake a fundamental reform of health care financing in almost five decades. It goes without saying that the ACA will have profound effects on health care financing and delivery in the United States for decades to come. My coauthors and I believe this book will continue to be a valuable tool for understanding not only the expected impacts of the ACA over the next decade, but for understanding the impacts of the other significant trends in health care that have been occurring independently of the ACA.

The likely consequences of the ACA will be addressed in varying degrees of depth in every chapter of this volume. Therefore, to set the stage for the rest of this book, the remainder of this chapter describes the major components of the law and discusses its likely impacts on major stakeholders in the health care system. But before dealing with the content of the law and its impacts, it is worth briefly reviewing how this law came to be after so many years of failed efforts to expand health insurance coverage to virtually all Americans.

Events Leading to the Enactment of the ACA

The evolution of the unique mix of private and public health insurance in the United States is discussed in more detail in Chapters Six, Seven, and Twenty-One of this volume and is summarized in two recent articles by Oberlander (2010; 2012). Briefly, the origins of the Affordable Care Act can be traced most directly to three significant events that occurred since the enactment of Medicare:

- The growth of managed care in the 1970s and the formulation of a proposal for national health care reform based on ''managed competition'' among insurers
- The failure of the Clinton Administration's proposal for health reform based on managed competition among managed care plans in 1993 and 1994
- The enactment of significant health reform in Massachusetts in 2006 based on managed competition, including subsidies for low- and middle-income individuals and families to purchase private insurance in regulated market places

Managed competition was first proposed by Professor Alain Enthoven of the Stanford Business School in the late 1970s (Enthoven, 1978). It was designed to build on the strengths of private insurance markets, but to correct their weaknesses through regulated competition. Enthoven's model of managed competition was based on the Federal Employees Health Benefits Program (FEHBP), which provides health insurance benefits to more than three million federal employees nationally through a regulated marketplace that offers employees multiple plan choices. In the political context of the 1970s, managed competition was viewed as a private-market alternative to liberal proposals for a single-payer health care system through, for example, the expansion of Medicare to all ages.

Enthoven proposed to standardize insurance policies to promote price comparison among similar products, so consumers could make ''apples-to-apples'' comparisons. He also proposed to address inefficiencies in the demand (the buyers') side of the market by pooling small companies and individual (nongroup) purchasers into larger groups known as health insurance purchasing cooperatives (HIPCs) and by providing vouchers (subsidies) for low-income individuals to purchase private insurance. HIPCs were a central feature of President Clinton's national health reform proposal and were the template for both the Massachusetts Insurance Connector established in 2006 and the American Health Benefit and Small Business Health Options Program (SHOP) exchanges included in the ACA.

After the recession of 1990 through 1991, millions of Americans lost their employment-based insurance, and the number of uninsured rapidly jumped from 35 million to 40 million between 1991 and 1993 nationally (DeNavas-Walt, Proctor, & Smith, 2011). President Clinton was elected in 1992 in part because he campaigned on a platform that proposed major health care reform with universal access. Although the Clinton plan,

known as the Health Security Act, was based on many of the principles of managed competition, it went further to include federal controls on premiums, national budgets, and perhaps most controversial of all to many Americans, a requirement that employers enroll their employees in managed care plans. This last element was very controversial because millions of those with employment-based insurance would be required to give up their insurance to join health maintenance organizations (HMOs), the most common form of managed care in the early 1990s.

After the failure of the Clinton plan to even move forward for a vote in Congress in 1994, major health reform seemed out of the question for the foreseeable future, and the first edition of this book contained language to that effect. Nevertheless, two significant expansions of health insurance occurred over the decade following the Clinton plan. One was the creation of the State Children's Health Insurance Program (SCHIP) in 1997, to be discussed further in Chapters Six and Eighteen. The other was the enactment in 2003 of Medicare Part D, the pharmaceutical drug benefit, which is discussed further in Chapter Twenty-One.

What caught many health policy analysts by surprise at the national level was the enactment of significant health reform in Massachusetts in 2006 based on an innovative combination of Medicaid expansion, subsidies for purchase of private insurance in a regulated market known as the Insurance Connector, and employer and individual mandates. Of course, this approach did not simply appear overnight; as explained by McDonough, Rosman, Phelps, and Shannon (2006), the road to reform in Massachusetts started in 2001 and represented the ''third wave'' of reform efforts that began under Governor Dukakis in 1988, just prior to his unsuccessful run for the presidency. One of the major forces driving the 2006 reform, however, was the threatened loss of almost $400 million dollars in funds under the state's Medicaid waiver with the Centers for Medicare and Medicaid Services (CMS), the federal agency that runs these programs, unless the state provided expanded coverage for the uninsured (Holahan & Blumberg, 2006). These diverse, concurrent pressures within Massachusetts in the early 2000s led to a unique compromise approach to reform, forged by Republican Governor Mitt Romney and Democratic legislative leaders, combining both conservative and liberal elements to achieve the goal of nearly universal access for all legal residents of the state. But the core of the Massachusetts reform reflected key elements of managed competition.

The successful enactment of significant health reform in Massachusetts in 2006—and the fact that it represented a genuine compromise between conservative and liberal proposals—immediately elevated the Mas-

sachusetts model as a template for feasible reform for the rest of the nation. Governor Schwarzenegger in early 2007 proposed legislation to implement a Massachusetts-style reform for California, perhaps hoping to replicate the bipartisan support for health reform. Although California's effort was ultimately unsuccessful, the attempt to enact such a reform in the nation's largest state virtually ensured that health reform would be a central issue in the 2008 presidential election.

The role of health reform in the 2008 election, the difficult path to eventual enactment of the ACA in March 2010, and the Supreme Court's decision to uphold the constitutionality of the individual mandate provision in June 2012 are discussed in more detail in Chapter Six. But, for the remainder of this chapter, it is important to remember that the major elements of the ACA were based directly on the following components of the 2006 Massachusetts reform: (1) expansion of Medicaid for those with the lowest income, (2) subsidies for low- to middle-income individuals and families to buy private health insurance in regulated markets, (3) and mandates for employers to offer insurance and for individuals who are legal residents to acquire insurance.

Major Provisions of the ACA

This section provides an overview of the major elements of the ACA. The final version of the law is over nine hundred pages in print and includes ten significant sections, or titles. Thousands of additional pages of federal regulations have been issued since the law's enactment on March 23, 2010, as part of the administrative rule-making process by which federal laws are implemented. This section cannot provide a comprehensive review of the entire law, so it focuses primarily on the small-group and individual (nongroup) market reforms and expansion of Medicaid contained in Titles I and II, respectively, of the law. More complete summaries of all the provisions of the law are available at www.healthcare.gov, which also includes the complete text version of the law, and at kff.org/health-reform.

Medicaid Expansion

Since the enactment of Medicaid in 1965, low-income individuals qualify for this program based on what is known as *categorical eligibility*. In effect, this means that eligibility is based on both low-income status and having a qualifying medical condition or need. As a result, simply being poor

has never been a sufficient condition to qualify individuals for Medicaid. The ACA fundamentally changes Medicaid eligibility by establishing a uniform, national eligibility standard based solely on income. Starting in 2014, Medicaid eligibility will be available to everyone with income up to and including 138 percent of the federal poverty level (FPL), which varies according to family size. For example, in 2013, 138 percent of the FPL is equal to $15,856 for an unmarried individual and $32,500 for a family of four. Because federal rules permit an offset of 5 percent of income in determining eligibility, the 133 percent FPL limit for Medicaid eligibility identified in the law is effectively 138 percent in practice (Angeles, 2011).

The ACA changes the federal matching assistance percentages (FMAPs) available to states for newly eligible Medicaid populations. As of 2013, states receive FMAPs that range from 50 to 77 percent for their existing Medicaid programs. Under the ACA, states will receive a 100 percent FMAP to cover their newly eligible Medicaid beneficiaries from 2014 through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent from 2020 onward. As a result, after 2014, states will receive a ''regular'' FMAP for individuals who would have qualified for their Medicaid programs as of 2013 and a separate, more generous FMAP for their newly eligible Medicaid population (Heberlein, Guyer, & Rudowitz, 2010).

Despite the ACA's effort to create Medicaid expansions in every state and the District of Columbia, the one component of the ACA found to be unconstitutional by the Supreme Court in June 2012 was the mandatory aspect of the law's Medicaid expansion. Specifically, the court found the provision of the law penalizing a state that did not expand their Medicaid program by eliminating all federal funding to the state for Medicaid was excessively punitive and struck down that provision of the law. Therefore, Medicaid expansion is now voluntary on the part of states, although states that choose to expand Medicaid must expand to 133 percent of FPL (or 138 percent of FPL accounting for the 5 percent offset). As of February 2013, twenty-four states are committed to Medicaid expansion in 2014, and another four are leaning toward expansion. The impact of the voluntary expansion of Medicaid will be discussed later in this chapter. More detail on Medicaid can be found in Chapter Six.

Subsidies to Purchase Private Insurance

For individuals and families between 139 and 400 percent of FPL who are above the Medicaid income eligibility threshold, the ACA will provide

subsidies to purchase private health insurance in regulated markets known in the law as American Health Benefit Exchanges, or now simply known as exchanges. For marketing purposes, individual states may rename their exchanges to a more consumer-friendly title; for example, California's exchange is known as Covered California, while Oregon's is Cover Oregon.

Eligibility for subsidies will be processed by the exchanges through income verification with the Internal Revenue Service. Income determination will be based on modified adjusted gross income (MAGI) from the most recent tax return, which is essentially the adjusted gross income from a tax filing unit's return plus any foreign or tax-exempt interest income (Angeles, 2011). Of course, exceptions will be made for those whose financial circumstances have changed, for example, through loss of employment. The amount of the subsidy is based on a sliding proportion of income (the MAGI) and the cost of the second-lowest-cost Silver plan (defined next) offered in the exchange. The personal share of the premium is determined by this sliding scale:

- 100 to 133 percent of FPL: 2 percent of income
- 133 to 150 percent of FPL: 3 to 4 percent of income
- 150 to 200 percent of FPL: 4 to 6.3 percent of income
- 200 to 250 percent of FPL: 6.3 to 8.05 percent of income
- 250 to 300 percent of FPL: 8.05 to 9.5 percent of income
- 300 to 400 percent of FPL: 9.5 percent of income

To illustrate, for a family of four in 2013, 400 percent of FPL is $94,200. Such a family would have a maximum contribution for health insurance of $8,949 (that is, 9.5 percent of $94,200). If the second-lowest-cost Silver plan in this family's exchange cost $12,000, they would be eligible for a subsidy of $3,051. The family is not required to buy a Silver plan, but their subsidy remains the same regardless of whether they buy a more or less expensive plan than the second-lowest-cost Silver plan.

In addition to premium subsidies, low-income individuals and families from 100 to 250 percent of FPL also qualify for subsidies to reduce their out-of-pocket expenses due to cost sharing (deductibles and copayments). However, to qualify for this additional assistance, qualifying individuals and families must purchase a Silver plan sold in their exchange.

The ACA intends for all individuals below 139 percent of FPL to be eligible for mandatory Medicaid expansions. The premium limit listed earlier for those from 100 to 133 percent of FPL is intended only to apply only for those legal residents with less than five years of residency

who are not eligible for Medicaid. However, because the Supreme Court overturned mandatory Medicaid expansion, those with income from 100 to 133 percent FPL will now be eligible for subsidies if their state has rejected the Medicaid expansion. Those with incomes below 100 percent of FPL in such states will continue to be without insurance, unless Congress finds another solution, which seems unlikely in the current polarized political environment.

Finally, subsidies in the form of tax credits are available to small employers to assist with their health insurance costs. For tax years 2014 and later, small businesses with fewer than twenty-five employees that purchase coverage through the state exchange can receive a tax credit of up to 50 percent of the employer's contribution toward health insurance premiums if the employer contributes at least 50 percent of the total premium cost. The full credit will be available to employers with ten or fewer employees and average annual wages of less than $25,000, and it phases out as firm size (maximum twenty-five) and average wage (maximum $50,000) increase. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35 percent of the employer's contribution toward health insurance premiums. The employer tax credit will be available for a maximum of two years to any individual firm. As described in the next section, because these firms employ less than twenty-five employees, they are exempt from the employer mandate under the ACA either to provide insurance or pay a tax penalty.

Mandates for Individuals and Employers

Perhaps the most controversial aspect of the ACA, at least in the period immediately following its enactment in 2010, was the so-called individual mandate, or minimum coverage requirement. The rationale for an individual mandate is that individuals will have no incentive to buy or enroll in insurance that requires them to pay a premium if insurers cannot deny insurance to anyone who seeks it and cannot charge higher premiums based on health status. In fact, the incentive in such a market is to sit on the sidelines until insurance is absolutely necessary. These circumstances can lead to adverse selection in the insurance market, where only those with high-use or severe illnesses seek insurance, while those who are relatively healthy avoid insurance until necessary. When adverse selection occurs, premiums spiral because only the sickest individuals seek insurance. To prevent this sort of market disruption, the Massachusetts reform and the ACA included an individual mandate requiring all legal residents to

demonstrate that they have minimal acceptable coverage or pay a penalty as part of their income tax return.

The constitutionality of the individual mandate was upheld by the Supreme Court in June 2012. Specifically, the court found that the mandate is constitutional because failure to comply with the mandate results in a tax, which is constitutional under Congress's taxation authority. Therefore, starting in 2014, legal residents will need to demonstrate that they have minimal acceptable coverage through either public insurance (Medicare, Medicaid, SCHIP, military insurance, or Veterans Administration coverage), employment-based coverage, coverage purchased through the exchange, or a grandfathered plan certified as acceptable by the Department of Health and Human Services and already in effect on the date the ACA was signed into law. Those who fail to demonstrate that they have such coverage will be required to pay a tax equal to:

- In 2014, $95 per adult and $47.50 per child, up to a family maximum of $285 or 1.0 percent of family income, whichever is greater
- In 2015, $325 per adult and $162.50 per child, up to a family maximum of $975 or 2.0 percent of family income, whichever is greater
- In 2016, $695 per adult and $347.50 per child, up to a family maximum of $2,085 or 2.5 percent of family income, whichever is greater

There are various exemptions from the tax: individuals who have religious objections, are members of an American Indian tribe, have income below the threshold required to file income taxes, are incarcerated, have to pay more than 8 percent of income for insurance, or are undocumented. The undocumented are generally excluded from all requirements and benefits under ACA, including the ability to purchase insurance inside the exchanges with their own funds. The ACA does include additional funding from safety net clinics, which serve a large portion of the undocumented population; further discussion of the undocumented and the role of the safety net under the ACA can be found in Chapter Twenty-Three.

In addition to the individual mandate, the ACA requires employers with fifty or more full-time equivalent (FTE) employees to provide affordable health insurance coverage or pay a penalty to the federal government, although this provision of the law has been delayed until January 1, 2015. This type of ''pay-or-play'' employer mandate was tried by several states over the past two decades, but in 2013 the only states with employer mandates are Massachusetts, which implemented its mandate in 2006, and Hawaii, which was the first state to enact an employer

mandate in 1974 (Buchmueller, DiNardo, & Valetta, 2011). Employer requirements under the ACA are illustrated in a useful flow chart that can be found at http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act.

Under the ACA, affordable coverage is defined as insurance where the employer share of the premium is at least 60 percent and no employee pays more than 9.5 percent of his or her income toward the employee share of the premium. For firms that do not offer insurance, the penalty is $2,000 annually times the number of full-time employees, but excluding the first thirty employees. For firms that offer insurance, but either pay less than 60 percent of the cost or have at least one employee who seeks an exchange subsidy because he or she has to pay more than 9.5 percent of their salary for the premium, the penalty is $3,000 times the number of full-time employees receiving a subsidy in the exchange, up to a maximum of $2,000 times the number of full-time employees minus thirty. These penalties are increased each year by the growth in insurance premiums.

Creation of Regulated Markets for Purchasing Private Insurance with Subsidies

The ACA requires individuals and families who qualify for subsidies, as well as small firms receiving tax credits starting in 2014, to purchase standard insurance policies and plans in regulated markets knows as exchanges. This section describes these marketplaces, the requirements for the standard health policies sold in these markets, and other reforms that apply both in and outsides the new exchanges. It is worth noting that the market reforms introduced by the ACA represent the first comprehensive federal regulation of private health insurance in U.S. history.

Individual Market Exchanges. The ACA requires states to establish individual (nongroup) market exchanges in time to begin enrolling new members by October 1, 2013. Because of ongoing efforts by conservatives to overturn and delay implementation of the ACA, as of February 2013, only eighteen states had declared their intention to establish an exchange, and seven others declared their intention to establish an exchange in partnership with the federal government. By default, the twenty-six remaining states will have exchanges operated by the federal government. Despite the potential for ongoing conflict over the ACA that federally run exchanges present, every state is expected to have an operating exchange in time for enrollment starting in October.

The role of the exchanges is to offer qualified health plans (QHPs) with essential health benefits (EHBs) (defined next), to offer four ''metal'' tiers (defined next) of QHPs that vary according actuarial value (AV) but that all offer minimum acceptable coverage, and to provide customer-friendly methods for purchasers to both determine if they are eligible for subsidies and to comparison-shop for competing health plans and policies all having the same EHBs. Exchanges can operate as active purchasers, in which they negotiate on premium prices or contract with only selected insurers, or as passive clearinghouses, in which they accept all qualified health plans into the exchange. State-run exchanges were eligible for federal funds to support their development from 2011 through 2013, and over $1.5 billion was awarded in 2013 to assist eleven states to finish building their exchanges. Exchanges will ultimately need to be self-sufficient, with the most likely source of revenue being a small surcharge on all policies and plans sold through the exchange. States that are relying on federally operated exchanges can apply to develop state-run exchanges in the future, but the availability of start-up funds is uncertain.

Small Business Health Options Program Exchanges. States are also required by the ACA to establish a small-group market exchange, known in the law as Small Business Health Options Program (SHOP) exchanges, and have the authority to sell affordable insurance to small employers with up to one hundred employees. States have the flexibility to establish SHOP exchanges using definitions of small employers below the statutory definition of one hundred employees. For example, California's SHOP exchange will initially be available only to employers with up to fifty employees. Small firms that qualify for tax credits must purchase insurance in the SHOP Exchange, but firms with fifty to one hundred employees are not required to buy insurance in the SHOP exchange to satisfy the employer mandate.

Qualified Health Plans with Essential Health Benefits. One of the major functions of exchanges is to certify qualified health plans (QHPs) for sale within the exchange. QHPs are health plans or policies with essential health benefits (EHBs), which were defined in the ACA to includes services in each of the following ten categories: outpatient, emergency, inpatient hospital, laboratory, maternity and newborn, mental health and substance abuse, prescription drugs, rehabilitative, preventive, and pediatric oral and vision. EHBs can vary across states and can be based on actual benchmark health policies or plans currently offered in each state, but must comply

with federal guidelines and must be expanded to include all ten categories of benefits just described if they don't currently cover such services. States have the option of designating an existing health insurance policy within the state to serve as its EHB benchmark, or, by default, the health policy with the largest enrollment in the small-group market will be designated as the EHB benchmark for that state. As of December 2012, nineteen states and the District of Columbia had designated a small-group plan as their EHB benchmark, four had selected a managed care plan, three had selected a state employee health plan, and twenty-four had the default small-group plan as their benchmark EHB.

In addition to providing coverage for EHBs, QHPs must comply with a number of other significant market reforms discussed in the next section.

Other Market Reforms. The ACA includes significant federal requirements affecting private health insurance markets for the first time. These requirements affect not only health plans and policies sold in the individual and SHOP exchanges starting in 2014, but all markets, including the large-group and self-insured employment-based insurance markets. These requirements include:

- Coverage for adult children up to their twenty-sixth birthday
- Prohibition on rescissions
- Prohibition of preexisting condition exclusions
- Elimination of annual and lifetime dollar limits on benefits
- Preventive services with no copays
- Medical loss ratio thresholds
- Premiums based on modified community rating
- Metal tiers of coverage based on actuarial value (AV)
- Minimum AV requirement
- Annual out-of-pocket limits

These requirements, their effective dates, and the insurance markets to which they apply are summarized in Table 1.1.

Large-group plans and policies will generally continue to operate outside of exchanges, unless a state decides to open its exchange to the large-group market after 2017. The additional requirements such a decision would impose on large employers are shown in Table 1.1. Grandfathered plans are exempt from most of the requirements listed earlier, as shown in Table 1.1. Such plans cannot be offered to new customers in the individual (nongroup) market, but can be offered to new

TABLE 1.1. SUMMARY OF MAJOR ACA REGULATIONS AFFECTING PRIVATE INSURANCE

ACA Regulations	Nongroup	Small Group	Large Group	Self-Insured	Grandfathered
After September 23, 2010					
Adult child coverage up to age 26	X	X	X	X	[1]
Rescissions prohibited	X	X	X	X	X
Preexisting conditions covered for ages <19	X	X	X	X	[2]
No lifetime dollar limits on benefits	X	X	X	X	X
Phased elimination of annual dollar limits on benefits by 2014	X	X	X	X	[2]
Preventive services without cost sharing[3]	X	X	X	X	
After January 1, 2011					
Medical loss ratio (MLR) thresholds	X	X	X		X
After January 1, 2014					
Modified community rating	X	X	[4]		
Essential health benefits (EHBs)	X	X	[5]		
Metal tiers of coverage	X	X	[5]		
Annual limits on out-of-pocket spending	X	X	X	X	
Subsidies to buy qualified health plans (QHPs)	[6]				
Minimum actuarial value of coverage	X	X	X	X	
Preexisting conditions covered for all ages	X	X	X	X	[2]

Small group = up to 100 full-time equivalent (FTE) employees; large group = more than 100 FTE employees.

[1] Until 2014, grandfathered group policies are exempt for adult children eligible for other employer-based coverage, such as through their own job.

[2] Policies in the nongroup (individual) market are exempt from this requirement.

[3] Additional preventive services for women required after August 1, 2012.

[4] Applies only in states that allow large employers to purchase in the exchange after 2017.

[5] Applies inside and outside the exchange for large employers in states that allow large employers to purchase in the exchange after 2017.

[6] For citizens and legal residents of fewer than five years who qualify for subsidies based on income, or who have unaffordable insurance or insurance that fails to meet the 60 percent minimum actuarial value requirement through their job.

Source: Adapted from Linder, Moore, & Udow-Phillips, 2012.

employees within firms that continue to offer grandfathered plans in the small-group market.

The requirement to provide coverage for adult children up to (but not including) age twenty-six has had the largest impact to date. An estimated 3.1 million young adults have become newly insured as a result of this provision of the ACA (Sommers, 2012). Prior to the ACA, employers often permitted adult children to stay on their parents' health insurance policies, but this practice usually applied only to children who were still financially dependent on their parents, usually because of college enrollment. Under the ACA, adult children no longer need to be financially dependent to remain on their parents' policy. Employers are not required to offer family coverage to employees under the ACA, but if they do, they must offer coverage for adult children.

The prohibitions on rescissions and on preexisting condition exclusions are related. Rescission refers to the practice of cancelling the insurance policy of someone after coverage is granted because of alleged omission of information about preexisting conditions on the application for insurance. Insurers have been accused of employing rescission to cancel the policies of policyholders who develop high-cost illnesses as a way to avoid paying for expensive claims. Preexisting condition exclusions allow insurers to issue insurance policies with specific exclusions for conditions that exist at the time someone applies for insurance or that are part of an applicant's medical history. They generally specify a time period during which the insurer is not required to provide benefits for the preexisting condition, although in some cases the exclusion is permanent (Georgetown University Health Policy Institute, 2012). Depending on the state, health insurers can also employ *medical underwriting* to avoid offering insurance, or to charge higher premiums, to those with preexisting conditions.

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 imposed limits on the look-back period (six months) and the duration of preexisting condition exclusions in the group market, but these protections don't extend to individuals in the nongroup market unless they had at least eighteen months of continuous coverage in the group market. Therefore, the ACA will provide significant new protections, particularly for those with preexisting conditions in the individual market. Preexisting condition exclusions were eliminated for children up to nineteen years of age for policy years starting after September 23, 2010; they are eliminated for all ages effective January 1, 2014, except for grandfathered plans in the individual market.

The elimination of lifetime and annual dollar limits on benefits provides catastrophic protection. Lifetime limits were prohibited for new and existing policy years starting on or after September 23, 2010. Annual limits are eliminated for all health plans and policies as of January 1, 2014, except grandfathered plans in the individual market.

Approved preventive services must be provided at no cost to the insurer member. Insurers cannot charge a copayment for preventive services, and those services must be exempt from deductibles. Preventive services that must be covered without cost sharing by insurers include all services graded as A or B by the U.S. Preventive Services Task Force (USPSTF), an independent panel of primary care providers that rates or grades the scientific evidence concerning the clinical effectiveness of various preventive services, including screening tests and immunizations. Services are graded A or B by the USPSTF when there is high certainty of substantial (A) or moderate (B) net benefit of performing the service. This ACA requirement was effective for all policy years on or after September 23, 2010, except for grandfathered plans, which are exempt. As of 2013, there are sixteen recommended preventive services for adults, twenty-two for women, and twenty-seven for children under age eighteen.

Medical loss ratio (MLR) thresholds require insurers to meet minimum payout requirements on the premiums they collect. Insurers in the large-group market must spend at least 85 percent of their premium revenue on medical expenses, while small-group and individual market insurers must spend at least 80 percent. The law requires insurers to issue rebates to employers or individual purchases by August 1 of the following year if they do not meet these minimum standards; the rebates must be sufficient to bring the insurer into compliance with the threshold. In 2012, insurer rebates were estimated $1.3 billion nationally (Cox, Levitt, & Claxton, 2012). Only self-insured employers are exempt from the MLR requirement.

On January 1, 2014, when the exchanges open for business, the small-group and individual markets are required to meet the following requirements both inside and outside of the exchanges (1) use of modified community rating to set premiums, (2) all policies must include essential health benefits (EHBs), (3) all policies must be one of four ''metal'' tiers, and (4) all policies must include limits on out-of-pocket spending by policyholders (this also applies to large and self-insured employers).

Modified community rating refers to the use of a limited set of demographic characteristics in setting insurance premiums. Under pure community rating, insurers charge a single premium to everyone. Under

the ACA's modified community rating requirements, insurers can use only the following characteristics in setting premiums:

- Age, limited to no more than a 3-to-1 ratio between the highest- and lowest-cost age group
- Tobacco use, limited to no more than a 1.5-to-1 ratio between smokers and nonsmokers
- Family size
- Geographic regions within a state

Perhaps most important, insurers are now prohibited from using health status as a basis for setting premiums. In addition, they are also required to comply with *guaranteed issue* and *guaranteed renewal* requirements—they must issue insurance to anyone willing to pay for it and renew any policyholder who wishes to continue with the same company. Furthermore, for insurers selling the same policy both inside and outside the exchange, they must charge the same premium for that policy in each market.

Metal tiers refer to the provision requiring insurers to offer standard health policies and plans in one or more of four coverage tiers based on actuarial value (AV). The Bronze tier must have an AV of 60 percent, meaning the premium should cover 60 percent of the costs for EHBs, while out-of-pocket spending by policyholders should cover the remaining 40 percent of costs. Bronze plan holders, therefore, pay less in monthly premiums, but have higher copayments or deductibles when they use health care services. The remaining tiers are Silver (70 percent AV), Gold (80 percent AV), and Platinum (90 percent AV). The law requires insurers to offer at least one Silver and one Gold plan to participate in the exchange, but as with other aspects of the law, states have the right to require insurers to offer three or four metal tiers, or to offer plans outside the exchange, as a condition for participating in the exchange.

In addition to the four metal tiers, insurers can also offer catastrophic policies with AVs below 60 percent that can be sold only to young adults under thirty years of age, or those who are exempted from the individual mandate because of financial hardship or lack of affordable coverage. Catastrophic plans have deductibles equal to the annual limit on out-of-pocket spending, discussed next, but must cover preventive services and three primary care visits at no cost to the policyholder.

It is important to note that all four tiers and catastrophic policies must include the same exact EHBs; what differs between the tiers is the relative share of costs covered by premiums versus policyholder out-of-pocket spending. Because all tiers must have the same EHBs, and within each tier

all policies must have the same AV, consumers should be able to make more informed choices between comparable policies. Within each metal tier, policies can still differ with regard to their schedule of copayments or coinsurance; there are many possible combinations to achieve the target AV. For example, one Bronze plan might require $500 copayments for each inpatient hospital day, while another plan might require a 30 percent coinsurance rate per day, but both plans cover 365 days of care per year. In theory, these market changes will promote greater price competition between insurers. To further promote ''apples-to-apples'' comparison shopping, some states, such as California, have gone beyond the ACA requirements, and are requiring insurers to offer standardized QHPs all having the same copayment or coinsurance schedules within a metal tier. Such standardization further promotes price competition among essentially identical insurance policies, down to the precise out-of-pocket requirements for copayments or coinsurance rates for each service.

Insurance in the large-group and self-insured markets does not need to comply with the metal tiers or EHB requirements, but must offer at least one plan that satisfies the 60 percent AV requirement. In these markets, whatever benefits are offered, the employer must either verify that they offer coverage with at least a 60 percent AV, or if self-insured, verify that they pay at least 60 percent of the total claims cost of the covered benefits.

Annual limits on out-of-pocket spending by policyholders are also required. All insurance policies, including large-group policies and self-insured employer plans, but excluding grandfathered policies, must comply with the federal out-of-pocket limits that apply to high-deductible health plans (HDHPs) approved for purchase in combination with health savings accounts (HSAs). For 2013, these limits are $6,250 for individuals and $12,500 for families, and are adjusted annually for inflation. The ACA provides for lower limits for individuals and families with incomes 100 to 250 percent of FPL who purchase Silver plans in the exchanges; the limits are one-third of the HSA limits for those 100 to 199 percent of FPL, and one-half of the HSA limits for those 200 to 250 percent of FPL. These lower limits, combined with additional federal subsidies to insurers for those from 100 to 250 percent of FPL who buy Silver plans, result in the higher AVs (that is, lower out-of-pocket spending) for those with the lowest incomes in the Exchange: 94 percent AV for those with incomes from 100 to 149 percent of FPL, 87 percent AV for those 150 to 199 percent of FPL, and 73 percent AV for those 200 to 250 percent of FPL. Finally, the ACA limits deductibles for policies and plans in the small-group market to $2,000 for individuals and $4,000 for families.

Future Directions

The ACA will have profound effects on health care financing and on reducing the number of uninsured legal residents and citizens in the United States. It may also serve as a catalyst for changing the organization and delivery of health care services by encouraging the development of new models of managed care known as accountable care organizations (ACOs). The remainder of this chapter briefly discusses the expected impacts of the ACA on each of the major stakeholders in the U.S. health care system for the remainder of this decade.

The Uninsured

Obviously, a primary goal of the ACA is to reduce significantly the number of uninsured in the United States. Specifically, the ACA was targeted at (1) those who were too poor to buy insurance but who didn't qualify for Medicaid because they lacked categorical eligibility or because they lived in a state with low income eligibility thresholds and (2) those who did not receive health insurance through their place of employment, largely because they worked for small employers who were less likely to offer health insurance benefits.

The Congressional Budget Office (CBO) estimated in 2010 that the ACA would extend coverage to 32 million uninsured nationally by 2019, including 16 million through the Medicaid expansion and another 16 million through the exchanges (CBO, 2010). Despite ongoing efforts by many states since 2010 to avoid complying with Obamacare, every state and the District of Columbia is expected to have exchanges operating by October 1, 2013. Therefore, CBO's estimate of 16 million fewer uninsured as a result of subsidies to purchase insurance in the exchanges is still relevant.

Because the Supreme Court found the mandatory expansion of Medicaid unconstitutional, conservatives are using opposition to the Medicaid expansion as a rallying cry in what appears to be a last stand against Obamacare. For the poor in states refusing to expand their Medicaid programs, there are few good alternatives at the time of this writing. The drafters of the ACA did not anticipate low-income individuals below 133 percent of FPL being excluded from Medicaid, because Medicaid expansion was mandatory in the legislation. However, the law does allow subsidies for individuals with incomes from 100 to 133 percent of FPL who don't qualify for Medicaid, mostly legal residents who have lived in the United States for

fewer than five years, so applying for exchange subsidies is an option for these individuals in states that don't expand Medicaid. But purchasing insurance will require these individuals to pay 2 percent of their income for insurance, while Medicaid would have been available at no cost. For individuals below 100 percent of FPL, there are no options for insurance if their state foregoes the Medicaid expansion.

As discussed earlier in this chapter, twenty-two states have announced as of February 2013 their intention not to expand their Medicaid programs, although eight Republican governors are pursuing the expansion. Clearly, political opposition to Obamacare may ebb in the future in states that refuse the Medicaid expansion, and the economic reality of forgoing hundreds of millions or billions of dollars in federal support for the uninsured may accelerate the erosion of current political opposition to Medicaid expansion. Until then, it is truly devastating from a public health perspective that as many as six million poor Americans (CBO, 2012a), mostly in the South and West, will be denied access to health insurance through Medicaid in 2014 and for the foreseeable future because of ongoing political opposition by well-insured voters in those states.

Employers

With regard to employers, some of the major questions regarding the impact of ACA are whether firms will (1) drop coverage if they offered it prior to 2015, (2) add coverage if they didn't prior to 2015, or (3) reduce the number of full-time employees (those averaging thirty hours per week) to avoid having to offer insurance benefits (Merlis, 2011).

Large employers with more than one hundred employees currently offer insurance to virtually all employees, and estimates are that 98 percent of large firms currently are in compliance with the ACA requirement to offer affordable insurance of with at least 60 percent actuarial value to their employees (Blumberg, 2010; Yong, Bertko, & Kronick, 2011). Therefore, there is little reason to believe that the large-group market will change in any measurable way as a result of the ACA.

There is speculation that employers in general will drop insurance coverage in favor of letting their employees buy insurance in the exchange. Employers who drop insurance and pay penalties could save significantly on employee benefits by pursuing such a strategy, but this strategy ignores the fact that employers were not required to offer insurance prior to 2015, so they could have chosen this cost-saving strategy at any time. Most large employers don't choose to drop coverage, because in a competitive labor

market health insurance benefits have considerable value in recruiting and retaining employees, particularly higher-income employees, who receive the most advantage from the tax-exempt status of health insurance benefits. Furthermore, companies that simply drop health insurance benefits without compensating their employees for the economic value of lost benefits should experience significant disadvantages in a competitive labor market.

CBO (2012b) estimates the net loss of employment-based insurance due to the ACA will be as much as five million individuals per year by 2019. This includes eleven million losing coverage because their employer stops offering coverage, three million who switch to receiving coverage through the exchange because their employment-based insurance is unaffordable, and nine million gaining insurance because their employer now offers insurance.

Regarding negative impacts of the ACA on employment, there are good reasons based on economic theory to be concerned. Some employers may hire fewer workers because the cost of employment has been increased for those firms. Employers may also reduce employee hours so that fewer workers qualify as full-time and thus are ineligible for health insurance benefits. However, the most relevant evidence is from Massachusetts, and the experience there suggests that these negative employment impacts were largely avoided (Dubay, Holahan, Long, & Lawton, 2012).

Hospitals

The hospital industry supported the ACA primarily because of the prospect of some thirty-two million newly insured individuals who would no longer require free care. But the ACA will reduce special subsidy payments to hospitals, known as disproportionate share hospital (DSH) payments, under both the Medicare and Medicaid programs, that compensate hospitals for the higher costs of serving a large portion of uninsured and low-income patients. The rationale for reducing these DSH subsidies is that as the number of uninsured patients declines under ACA, the need for DSH payments should also decline. Although the industry supported this rationale, there are clearly some safety-net hospitals that may fare worse under ACA. For example, public hospitals in Los Angeles County, where more than a million residents are likely to remain uninsured because they are undocumented or don't sign up for Medicaid, may not experience a significant increase in their share of patients with insurance (Lucia et al., 2012). As a result, traditional safety-net providers see the ACA as a potential mixed

blessing, particularly if newly insured patients begin seeking care at other, non-safety-net hospitals.

Physicians

Physicians are largely unaffected by the ACA. However, the substantial increase in the number of people with insurance has raised concerns about the adequacy of the supply of physicians to meet the expected increase in demand for physician services. For individuals with exchange insurance plans, access should be less of an issue, because they will be privately insured. The Medicaid expansion population is more likely to have access problems, particularly in states such as California where Medicaid payment rates are so low that physicians are reluctant to treat Medicaid patients.

There are several options in the short term to meet the increased demand for primary care services. One is to expand state scope-of-service laws, allowing nonphysicians to legally provide certain primary care services. Another is to increase the availability of care at community clinics, including federally qualified health centers (FQHCs), which serve low-income and uninsured populations. The ACA includes increased funding for FQHCs for this reason. Another is to increase payments for primary care services under Medicaid, which is also a provision under the ACA. The federal government paid states to raise their Medicaid payment rates for primary care services to Medicare levels, but only for 2013 and 2014. Lack of access to specialty care services has been a long-standing concern for Medicaid beneficiaries and may be worse under the ACA (Kaiser Commission on Medicaid and the Uninsured, 2011). As discussed in Chapters Two, Three, Four, and Five, access to adequate care requires more than access to health insurance.

Payers

The ACA will significantly affect all major payers of health care, largely because of the increased funding for federal subsidies to purchase private insurance and the Medicaid expansion. To achieve savings in federal expenditures so that the overall legislation was budget-neutral, the ACA also included significant reductions in Medicare expenditures over the next ten years.

Private Insurers. The private insurance industry is one of the biggest winners under the ACA, primarily because of the tens of millions of individuals

who will be newly insured. In exchange for allowing federal regulation of their business, private insurers stand to gain almost $1 trillion in additional revenue during the next decade as a result of the ACA. Even the Medicaid expansion benefits private insurers, because many states use private managed care plans to provide care to their Medicaid beneficiaries. In 2010, about 70 percent of the sixty million Medicaid beneficiaries nationally were enrolled in managed care (Sparer, 2012).

One fundamental issue that will unfold over the next decade is whether the increased reliance by government on private insurers will lead to significant innovations in health care delivery systems and control of costs. Or will significant additional reforms be necessary within the next ten years because the ACA has created subsidies and an expansion of Medicaid that prove to be unsustainable? The private insurance industry was largely supportive of the ACA because of the appeal of significant additional revenues, but will private insurers fully engage in vigorous price competition or increase lobbying efforts seeking a relaxation of federal regulations as ACA implementation moves forward? The next decade will provide a fascinating and once-in-a-lifetime opportunity to determine whether regulated competition of private health insurers at the state level can produce a more efficient, high-performance health care system.

Medicare. Medicare is largely unaffected by the ACA, with a few notable exceptions. CBO (2012c) estimates that Medicare savings will amount to $716 billion from 2013 through 2022, mostly due to lower inflation allowances for payments to hospitals and other facilities, lower payments to Medicare managed care plans, and lower DSH payments to hospitals. In addition, Medicare revenues will increase starting in 2013 due to a higher withholding tax rate (2.35 percent for the employee share only) for those with income greater than $200,000 for single and head of household tax filers or income greater than $250,000 for married taxpayers filing jointly. A new Medicare tax of 3.8 percent went into effect on unearned income starting in 2013. Although these savings and additional revenues in Medicare do not directly support the federal funding available for ACA, they did count toward the CBO ''scoring'' of the ACA's federal budgetary impacts and led CBO to conclude that the ACA would not increase the federal budget deficit during the decade from 2013 through 2022 (CBO, 2010).

The ACA includes two other provisions related to Medicare that could have broader significance for the U.S. delivery system. One is the creation of the Center for Medicare and Medicaid Innovation (CMMI). CMMI is supporting the development of new mechanisms for coordinating care

under the Medicare program known as accountable care organizations (ACOs). More information on ACOs can be found in Chapter Twenty. The other provision is the creation of a new agency known as the Independent Payment Advisory Board (IPAB). In contrast to the Medicare Payment Advisory Commission (MedPAC), which advises Congress on changes to the Medicare program, IPAB has the authority to implement changes in Medicare payment policies to reduce the growth of Medicare expenditures if those expenditures exceed targeted growth rates. However, because IPAB's fifteen members must be appointed by the president and approved by the Senate, as of this writing in early 2013, no IPAB board members have been appointed. IPAB continues to face considerable opposition from conservative groups as well as from medical professionals, so its future remains uncertain.

Medicaid. The fact that the Medicaid expansion is now voluntary obviously reduces the effectiveness of this option for reducing the number of uninsured who are poor. Medicaid has been successful over the past four decades in improving access to health care and the health status of beneficiaries, as discussed in Chapters Two, Three, and Six. By increasing the federal commitment to Medicaid, the ACA builds on both the strengths and weaknesses of that program and allows for existing variation between states in the effectiveness of their Medicaid programs to continue (Kaiser Commission on Medicaid and the Uninsured, 2011). The success of the Medicaid expansions may in fact be crucial to future public support for the ACA. Because the ACA significantly increases our nation's federal commitment to fund health insurance for the poor, evidence that the expansions are not working smoothly or that government funds are not being well utilized will be used to fan the flames of ongoing opposition and as ''proof'' that the law was ill conceived. Supporters of universal access to care and equality for the poor cannot afford to squander this once-in-a-lifetime opportunity to dramatically increase access and health status for our uninsured population.

SUMMARY

The ACA is likely to change the landscape of health care financing in the United States as dramatically as Medicare and Medicaid did in 1965. Political opposition to the law is diminishing, but remains active,

particularly in southern and western states with Republican governors and Republican majorities in the state legislatures. Whether this opposition will diminish more rapidly after the major provisions of the law discussed in this chapter go into effect in 2014 remains an open question. There is no question, however, that tens of millions of Americans will have access to more affordable insurance starting in 2014. Sustaining political and taxpayer support for the ACA throughout the next decade will be an enormous challenge. If the Medicare and Medicaid programs have taught us anything over the last five decades, it is that federal health insurance programs have to evolve and innovate to remain viable.

KEY TERMS

Actuarial value (AV) the portion of a health insurance policy's total costs for covered benefits covered by the premium, as opposed to the portion of costs paid for directly by policyholders at the time of service in the form of out-of-pocket deductibles and copayments. A policy's AV is based on the average experience of everyone who is covered by that particular insurance policy.

Essential health benefits (EHBs) ACA provision that requires insurers to offer health policies or plans with benefits in ten categories of services: outpatient, emergency, inpatient hospital, laboratory, maternity and newborn, mental health and substance abuse, prescription drugs, rehabilitative, preventive, and pediatric oral and vision. EHBs can vary across states, and can be based on actual benchmark health policies or plans currently offered in each state, but must comply with federal guidelines and must be expanded to include all ten categories of benefits described above if they don't currently cover such services.

Exchanges regulated private health insurance marketplaces where individuals receiving subsidies under the ACA can purchase qualified health plans (QHPs).

Federal poverty level (FPL) amount of income needed according to the U.S. Census Bureau to avoid living in poverty. The FPL depends on family size and is updated annually, but does not vary geographically, despite significant differences in the cost of living across the United States. For 2013, the FPL is $11,490 for a single individual and $23,550 for a family of four.

Guaranteed issue requires insurers to issue a policy to anyone able to pay for it, regardless of their health status or medical history.

Guaranteed renewal requires insurers to renew the existing policy of any policyholder as long as they are able to pay for it, regardless of their claims history, health status, or medical history.

Managed competition a model for health care reform proposed by Alain Enthoven in the late 1970s based on the Federal Employees Health Benefits Program. Its key elements are (1) price competition in regulated insurance markets between insurers based on standard insurance policies and (2) pooling of small companies and individual purchasers into larger groups known as health insurance purchasing cooperatives. Enthoven's managed competition model is the conceptual basis for the market reforms adopted under the ACA.

Medical loss ratio (MLR) thresholds require insurers to meet minimum payout requirements on the premiums they collect. Insurers in the large-group market must spend at least 85 percent of their premium revenue on medical expenses, while small-group and individual market insurers must spend at least 80 percent. The law requires insurers to issue rebates to employers or individual purchasers by August 1 of the following year if they do not meet these minimum standards; the rebates must be sufficient to bring the insurer into compliance with the threshold.

Medical underwriting insurer practice of using information about an applicant's medical history health status and preexisting conditions to establish premiums or to deny coverage for those with high-cost medical conditions. The ability of insurers to engage in medical underwriting varied according to state law prior to the ACA, which essentially outlaws the practice as of January 1, 2014.

Metal tiers ACA provision that requires insurers to offer standard health policies and plans in one or more of four coverage tiers based on actuarial value (AV). The Bronze tier must have an AV of 60 percent, meaning the premium should cover 60 percent of the costs for covered benefits, while out-of-pocket spending by policyholders should cover the remaining 40 percent of costs. Bronze plan holders, therefore, pay less in monthly premiums, but have higher copayments or deductibles when they use health care services. The remaining tiers are Silver (70 percent AV), Gold (80 percent AV), and Platinum (90 percent AV). It is important to note that all four tiers must include the same exact EHBs.

Modified community rating ACA provision that permits insurers to set premiums for qualified health plans (QHPs) inside exchanges as well as policies outside exchanges in the small-group and individual markets after January 1, 2014, based on only a limited set of personal factors, specifically, age, tobacco use, family size, and geographic area. Health status and medical history may not be considered in setting premiums.

Qualified health plans (QHPs) health insurance policies or health plans approved for sale within exchanges under the ACA. QHPs must offer the essential health benefits (EHBs) package approved within a particular state.

DISCUSSION QUESTIONS

1. The ACA represents a political compromise by providing subsidies to purchase private insurance in regulated markets to those who don't qualify, can't afford, or aren't offered health insurance through their job, rather than, for example, an expansion of eligibility for Medicare. Do you think the ACA will stabilize employment-based insurance in the future? Or will further government intervention be necessary to further ''fix'' the private market for health insurance? In your opinion, is the ACA too much or not enough reform? Why?
2. The exchanges will be offering standard health insurance plans and policies, all with EHBs and all fitting into one of four metal tiers based on their AVs. Do you believe standard benefits and standard tiers will both increase transparency and increase price competition between insurance policies? If price competition doesn't increase, is that because it is impossible to create competitive markets for health insurance, or is the ACA flawed in its design?
3. Because the implementation of the ACA allows for some significant variation across states in how to comply with the law's requirements, discuss the status of the state in which you are currently residing. Given your state's choices regarding EHBs, type of exchange (state-run, state-federal partnership, or federally run), Medicaid expansion efforts, and so forth, how would you assess the impact of the ACA in your state to date? Specifically, has the exchange in your state gained broad market recognition, and does it appear to be operating effectively?

FURTHER READING

Kaiser Family Foundation website on health reform: http:// kff.org/health-reform

This website contains numerous valuable documents explaining the components of the Affordable Care Act, including a detailed summary of the law, timeline for implementation, and flow charts showing employer and individual responsibilities (or mandates) under the law.

Oberlander, J. (2012). Unfinished journey: A century of health care reform in the United States. *New England Journal of Medicine, 367*, 585–590.

An excellent account of the long road to health reform and universal access in the United States.

Official federal government website on health reform: http://www.healthcare.gov

This website contains valuable information on various elements of the Affordable Care Act, including a consumer-friendly format and presentation style intended to explain various aspects of the law to the general public.

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