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ACA, Four Years After Enactment–Looking Back and Seeing What's Ahead

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Executive Summary

The fourth anniversary of the enactment of the Patient Protection and Affordable Care Act (ACA) occurred within days of the close of the first open enrollment period for individuals to purchase insurance through one of the new state-based or federal health insurance Exchanges. An estimated 7 million people chose insurance coverage through an Exchange; about 3 million people enrolled in Medicaid from October 1, 2013, to the end of March 2014. The close of open enrollment is a good point to look back at how the ACA has been implemented over the past four years, and to look ahead to new milestones and challenges to the law in 2014 and beyond.

Upon enactment in March 2010, the law had an immediate impact on many Americans. Children could stay on their parents' health plans until age 26. Individuals with pre-existing conditions who had been unable to purchase health insurance in the private marketplace were eligible to participate in a high risk pool that made it possible for them to get coverage. States could immediately expand their Medicaid programs to cover more people. Medicare payment rates for institutions were adjusted to change the incentive for payment from the number of services provided to the quality of services provided. Medicare beneficiaries who were enrolled in the prescription drug benefit program started receiving relief from the coverage gap, known as the 'donut hole," to help reduce out-of-pocket spending on drugs.

Throughout the last four years, many states and the federal government, worked to establish the health insurance Exchanges, while at the same time health insurance companies created new insurance products that conformed to the new law. While all this was going on, opposition to the implementation ran high, with Republicans in the House of Representative voting over 50 times to repeal the law, and many private citizens and groups filing lawsuits in federal and state courts for various reasons, though primarily against the regulations requiring all employers to include coverage for contraception and family planning services in their health plans.

This white paper provides an overview of the law itself; highlights the changes and additions to the Social Security Act, the Internal Revenue Code, and other statutes; spotlights the work of the various agencies involved in issuing the implementing regulations and guidances; and examines the significant challenges to the law in federal and state courts.

The Law Itself

The American health care system is a complex structure financed by a combination of private and public health insurance programs. For decades,

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most people who have private insurance have received coverage through their employers. Medicare—financed and administered by the federal government—has provided comprehensive health coverage for seniors and the disabled since 1966. Medicaid—financed and administered jointly by the federal and state governments—provides health coverage for a limited but clearly defined population of low-income people. There are various other health programs for Native Americans, veterans, and other groups. Finally, there are people who are uninsured, by circumstance or choice, who pay for health care services out of pocket, depend on hospital emergency rooms for health care, or just go without any health care services.

Since Medicare and Medicaid were enacted, politicians of both political parties have attempted to reform the private insurance market, because a substantial number of people—15 to 18 percent of the population on average—has not qualified for any type of health insurance. In 1992, President Clinton was elected in part because of his campaign goal to enact comprehensive health insurance reform, but his ambitious plan never even received a vote in Congress. Piecemeal reforms, such as making it somewhat easier for people who lost insurance coverage after losing a job to stay insured, or expanding Medicare to include a prescription drug benefit, have passed with bipartisan support. But comprehensive health reform remained elusive until the ACA was passed – with virtually no support from Republican members of Congress.

***Did you know* that the Affordable Care Act is actually two separate laws enacted in the same week in March 2010?**

The Patient Protection and Affordable Care Act (P.L. 111-148) (ACA), at 906-pages, contains the bulk of the law that established health insurance exchanges, the individual and employer mandate, essential health benefits, and many other reforms of both the private health insurance market and public programs such as Medicare and Medicaid. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (HCERA) is a 55-page law enacted a few days later that amends many provisions of the first law, and also includes key non-health reform related provisions that were designed to help pay for health reform. Many of these changes related to changes in funding for federal student loan programs.

***Did you know* that there were 383 unique law provisions in ACA, and 55 in HCERA?**

These numbers don't tell the whole story, however. Just two provisions of ACA added 17 new sections to the Public Health Service Act. These sections include most of the private health insurance market reforms, including coverage of preventive health services, expansion of dependent coverage, prohibition of preexisting conditions exclusion, and guaranteed renewability of coverage. Seventeen of the 55 HCERA provisions relate to changes in funding in federal student loan programs.

***Did you know* the law itself became effective over several years, and some parts of the law will not go into effect until 2015 or 2016?**

The laws as passed had almost 60 different effective dates. Since the ACA was enacted, a few other laws have been enacted that repeal certain ACA sections or further delay effective dates. For example, the American Taxpayer Relief Act of 2012 (P.L. 112-240), repealed ACA Title VIII, the Community Living Assistance Services and Supports (CLASS) Act. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) eliminated the limitation on deductibles for employer-sponsored health plans. In addition, the Obama administration, either by regulation, blog post, FAQ posting, or other communication, has delayed the effective date of part of the ACA several times. The most significant delay of this sort affects the employer mandate, which has been delayed twice since the ACA was enacted and now does not go into effect for employers of between 50 and 99 employees until 2016. Other administrative delays affect online enrollment by the Small Business Health Options Program (SHOP) Exchanges; verification of possible employer coverage and individual income by state health exchanges; implementation of the Basic Health Plan (designed for individuals who are not eligible for either Medicaid or a health insurance premium subsidy through a health insurance exchange); and limitations on group health plan cost sharing.

Changes to Existing Laws

Since the ACA was enacted, most of the attention has been on changes in the private insurance market, which isn't surprising because the law at its core is intended to reduce the number of people without health insurance as well as control annual increases in health spending. But the almost 1,000 pages of legislation made changes to 15 previous laws and significant amendments or additions to statutes like the Internal Revenue Code (IRC), the Social Security Act (SSA), and the Public Health Service Act (PHSA), not all of which are directly related to the private health insurance market.

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Social Security Act

SSA Titles 11, 18 and 19 include the laws governing the Medicare and Medicaid programs. Every session of Congress, dozens of bills are introduced that, if enacted, would revise these two programs. Most of the legislation never progresses past the introduction stage. But every few years, Medicare and Medicaid changes that are part of smaller bills become attached to a larger bill, usually an omnibus budget bill or, in the case of the ACA, what might be considered an omnibus health care bill. The ACA became the vehicle for dozens of Medicare and Medicaid changes that previously had been introduced but not acted on by Congress.

***Did you know* the ACA made over 400 changes to the SSA, with over 200 new Medicare and Medicaid provisions?**

Many of the ACA's Medicare changes impacted how providers who participate in Medicare get reimbursed. For years, CMS has been trying to reform the Medicare payment system away from the fee-for-service model that has existed for over 40 years to a system where providers are paid not by how many procedures or therapies beneficiaries receive but on the quality of care delivered. Under the ACA, most providers and practitioners will have to demonstrate that they are meeting specific quality standards, or they will receive less reimbursement for treating Medicare patients. Moreover, physicians must now have a face-to-face encounter with a Medicare beneficiary before certifying the medical necessity of home health services or durable medical equipment (sec. 6407).

In addition to reforming Medicare payments, the ACA created a new Center for Medicare and Medicaid Innovation (sec. 1115A) to test new payment and service delivery models for the two programs. The law also introduced what is known as the "Physician Sunshine Act" (sec. 6002), in an attempt to provide transparency by requiring the reporting of payments or gifts to physicians, and physician ownership and investment interests. The law instituted new accountability requirements for skilled nursing facilities and nursing facilities.

The most significant addition to Medicaid law was the statute that all states were required, starting in 2014, to expand their programs to cover individuals with incomes of up to 133 percent of the federal poverty level (sec. 2001). This was the only ACA section overturned by the U.S. Supreme Court in NFIB v Sebelius in 2012. Among the other major additions to Medicaid laws, the ACA expanded the Recovery Audit Program to include Medicaid (sec. 6411) and included several other provisions directly aimed at controlling fraud and abuse in the Medicaid program (for example, secs. 6402, 6504, 6506, 6507 and 6508); established a Nursing Home Compare website (sec. 6103), established procedures to simplify enrollment and coordinate enrollment processes with the new state health insurance exchanges (sec. 2201); and introduced a new "health home" benefit to serve Medicaid beneficiaries with certain chronic conditions.

In addition, the Obama administration, either by regulation, blog post, FAQ posting, or other communication, has delayed the effective date of part of the ACA several times.

Medicaid changes to existing statutes included expanding the authority of the Medicaid and CHIP Payment and Access Commission (sec. 2801); requiring new data collection on health disparities under Medicaid and the Children's Health Insurance Program (sec. 4302); the addition of smoking cessation therapy benefit for pregnant women (secs. 2001, 4107, and 10201); expanded preventive health services for adults (sec. 4106); and new requirements for skilled nursing facilities and nursing facilities regarding the ownership and organizational structure of their facilities (sec. 6101).

Public Health Service Act

The Public Health Service Act has 33 titles, covering a wide gamut of health subjects. The Public Health Service is part of HHS. Most of the private insurance related changes included in the ACA impacted the PHSA.

***Did you know* the ACA made almost 200 changes to the PHSA, with over 100 new provisions put in place?**

PHSA changes enacted by the ACA include the limitation on preexisting conditions used to determine premium rates (secs. 1201, 1252, and 10103); a prohibition on discrimination by health insurers against individuals based on health status (secs. 1001, 1201, 1253, 1255, 10103); guaranteed renewability of coverage (sec. 1201); prohibition on excessive waiting periods to receive health coverage (secs. 1201, 1253,

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1255, and 10103); no lifetime or annual limits (secs. 1001 and 10101); prohibition on rescissions (sec. 1001); and coverage of specific preventive health services (sec. 1001). (The regulations governing this last provision are the focus of most of the litigation related to ACA since it was enacted; the U.S Supreme Court on March 25 will hear arguments on the contraception coverage mandated under this provision.)

Many of the new or amended PHSA provisions are aimed at expanding the health care workforce at all levels. To name just a few, the ACA provides for: a new U.S. Public Health Sciences Track to provide advanced degrees to physicians and other medical and public health professionals (sec. 5315); grants to nurse-managed health clinics (sec. 5208); grants for a National Health Services Corps focusing on preventive and public health programs for underserved communities (secs. 5606 and 10501); a grant program for new or expanding primary care residency programs (sec. 5508); grants for programs to provide dental services in underserved communities (sec. 5304); training programs for community health workers to promote health behaviors in medically underserved areas (sec. 5313); grants for school-based health centers (secs. 4101 and 10402); training for direct care workers (sec. 5302) and general and pediatric dentistry (sec. 5303); and education and training related to geriatrics (sec. 5305).

PHSA provisions are added and amended to provide targeted grants and programs for women's health, dental health, depression services, emergency medicine, substance abuse and mental health services. The ACA also changes several PHSA provisions relating to the student loans of health care providers, nurses, public health officials, and others in the health care field in exchange for working in medically underserved areas.

Internal Revenue Code

Key parts of the ACA are the individual mandate to carry qualified health insurance, and a mandate on most employers to provide health insurance coverage to their employees. The mandate is enforced by the Internal Revenue Service, with individuals (secs. 1501 and 10106) or employers (sec. 1513) required to make a "shared responsibility payment" if they don't comply with the mandate.

***Did you know* the ACA made about 100 changes to the IRC with over 40 new provisions put in place?**

The ACA added four new requirements for hospitals to maintain their 501(c)(3) tax-exempt status: conducting a community health needs assessment; implementing and publicizing a written financial assistance policy; limiting charges to patents who qualify for financial assistance; and limiting bill collection procedures until a patient has been informed about the hospital's financial assistance policy (secs. 9007 and 10903).

In addition to the tax laws regarding the insurance mandate and tax-exempt hospitals, the ACA also modified the IRC to provide a 35 percent tax credit for small employers for premiums it pays on health insurance for its employees (secs. 1421 and 10105); a 50 percent tax credit for eligible investments for qualifying therapeutic discovery projects (sec. 9023); an increase in the threshold to claim an itemized deduction for unreimbursed medical expenses (sec. 9013); an additional 0.9 percent Medicare tax on high income taxpayers (secs. 9015 and 10906); a 40 percent excise tax on so-called "Cadillac" health plans, starting in 2018 (secs. 9001 and 10901); a 10 percent excise tax on indoor tanning services (secs. 9017 and 10907); and a 2.3 percent excise tax on medical devices (sec. 1405 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Other Law Changes

Some of the other laws that ACA amended or added to include the Employee Retirement Income Security Act (ERISA) eight changes; one new provision); the Fair Labor Standards Act (FSLA) (five changes; three new) and the Food, Drug, and Cosmetic Act (FDCA) (ten changes; one new).

A new provision of the FDCA updated requirements for an abbreviated new drug application (ANDA) with a proposed label differing from the label of the originator. Two new sections of the FSLA require employers of more than 200 employees to enroll new employees automatically in the employer's health plan and inform new employees so they have the option to opt out. New ERISA sections prohibit false statements regarding multiple employer welfare arrangement (MEWA) plans and establish that persons who provide insurance to MEWAs are subject to the insurance laws of the states in which the person operates.

Student Loan Reform

***Did you know* the ACA includes 17 sections amending the federal Pell Grant program and federal student loan programs?**

Secs. 2101 through 2213 of the Health Care and Education Reconciliation Act (P.L. 111-152) are not directly related to any of the private health insurance

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reforms, Medicare and Medicaid changes, or Public Health Service revisions and expansions in the rest of the law. In effect, the changes ended subsidies given to private institutions to guarantee federal student loans and made these federal loans direct loans to students.

At the time the ACA was enacted, the Congressional Budget Office (CBO) estimated that this transformation of the federal student loan program would save $61 billion over 10 years, and all the education changes would reduce federal government spending by $19 billion over 10 years. In 2010, this represented 15 percent of the total savings that the CBO saw coming from enactment of the ACA over 10 years.

Regulations

The ACA is being implemented by several federal agencies, most significantly by the Department of Health and Human Services (and related agencies such as the Centers for Medicare and Medicaid Services, the Social Security Administration, and the Food and Drug Administration) and the Department of Treasury (primarily via regulations issued by the Internal Revenue Service).

***Did you know* that since the law was enacted, federal agencies have issued over 150 final rules, with about 1,000 pages of new or amended regulations?**

There are more than 700 individual regulations that implement some part of the ACA. There are over 120 regulations relating to the health insurance exchanges.

New regulations and amendments to existing regulations regarding the ACA are issued on a regular basis. According to the "unified agenda," which lists upcoming proposed or final rules, some of the ACA-related rules that may come out later in 2014 or next year include—

- ***Revisions to the Medicare Incentive Reward Program (ACA sections 6402(j) and 6503).*** This rule would increase the incentive for individuals to report fraud, improves CMS's ability to detect new fraud schemes, and helps to ensure that potentially fraudulent entities and individuals do not enroll in or maintain their enrollment in the Medicare program.
- ***Revisions related to the Public Health Service Act Sec. 340B drug pricing program (ACA sec. 7102).*** HHS has issued proposed rules regarding increased civil money penalties and a binding administrative dispute resolution process to resolve claims raised by covered entities, but has not yet issued final regulations for either.
- ***Implementation of section 311(c)(1) of the Indian Health Care Improvement Act (IHCIA) (ACA sec. 10221).*** A proposed rule is expected to establish standards for the planning, design, construction, and operation of health care and sanitation facilities serving Indians under the IHCIA. Additionally, these regulations would stipulate which departmental regulations would be applicable to these activities.
- ***Reporting and returning of overpayments (ACA sec. 6402(a).*** In 2012, CMS issued a proposed rule which would require the Secretary to establish a process for a provider or supplier to return an overpayment to the Medicare program as well as establish a process for CMS and its contractors to receive and apply the overpayment. A final rule has not yet been issued.

Many of the new or amended PHSA provisions are aimed at expanding the health care workforce...

- ***Skilled nursing facility required disclosure of ownership (ACA 6101).*** These requirements were initially proposed in the SNF prospective payment system for FY 2012 proposed rule published on May 6, 2011; final regulations have not been issued.
- ***Medicare Shared Savings Program, final waivers (ACA sec. 3022).*** CMS issued an interim final rule on this program in 2011; a final rule is expected later in 2014.
- ***Automatic enrollment in health plans of employees of large employers (ACA sec. 1511).*** The ACA added section 18A to the Fair Labor Standards Act to require employers who have more than 200 full-time employees and who offer enrollment in one or more health benefits plans to automatically enroll new full-time employees in one of the plans offered and continue enrollment of current employees. The Department of Labor has yet to issue rules to implement this provision.

Administrative Guidance and Rulings

In addition to issuing and amending regulations, different federal agencies had administrative responsibilities mandated by ACA.

***Did you know* that over 1,200 final rules, proposed rules, notices, cases, administrative decisions, guid-**

ance documents, sample forms, advisory and oversight reports, and sets of frequently asked questions (FAQs) have been issued by various federal agencies and courts related to implementation of the ACA since March 2010?

CCIO. CCIO oversees the implementation of the ACA's various health insurance market reforms and has been particularly active in the establishment of the new Health Insurance Marketplaces. Since the law's enactment, the CCIO has issued over 60 sets of ACA-related FAQs, including topics such as consumer assistance program grants, the pre-existing condition insurance plan, Health Insurance Marketplaces, the navigator program, plan management, Marketplace planning and establishment grants, territory cooperative agreements, the premium stabilization program, the Consumer Operated and Oriented Plan (CO-OP) program, COBRA, health insurance market reforms, annual limits, coverage for young adults, review of insurance rates, student health plans. The CCIO also has issued dozens of model notices, sample forms, instructions and guidances, and fact sheets with updated data on enrollment trends and other matters.

IRS. The IRS is in charge of administering the various tax provisions contained in the ACA. Since 2010 it has issued over 120 revenue procedure documents, over 75 revenue rulings, and dozens of other guidance documents and fact sheets addressing various provisions of the ACA.

CMS. CMS has issued 64 letters to state survey and accreditation agencies, state Medicaid directors, and state health officials providing further guidance on ACA implementation relating to Medicaid and the Children's Health Insurance Program. CMS and its different subagencies also have issued almost 100 other guidance documents on different aspects of the ACA.

In addition to the guidance documents there have been a handful of administrative rulings related to specific ACA provisions. The HHS Departmental Appeals Board has issued six rulings relating to the Early Retiree Reinsurance Program, which operated until January 2014. In 2010, the CMS Administrator reviewed 24 decisions of the Medicare Geographic Classification Review Board issued after the March 2010 enactment of the ACA, all related to ACA sec. 3137, which extended reclassifications of hospitals for the purpose of adjusting payment rates based on difference in hospital wage levels to September 30, 2010.

FDA. The FDA has issued a few final rules and guidance notices related to the limited number of provisions found in the ACA, mainly about nutrition labeling of menus.

Agency Reports

The ACA placed demands on specific federal oversight and advisory groups, such as the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO) to make regular reports on specific topics. Since enactment, the OIG has issued almost 100 reports and the GAO has issued over 60 reports.

The Courts

While these agencies have been working to get the law up and running, various aspects of the law have been litigated in federal and state courts.

Did you know **that almost 150 federal district and appellate court decisions relating to the ACA have been issued since 2010?**

The most significant decision, of course, was the U.S. Supreme Court's ruling in June 2012 that upheld the ACA, except for one significant change. The ACA as enacted required states to expand eligibility for their Medicaid programs or risk losing all of the federal share of Medicaid funding; the Court ruled this part of the law was unconstitutional and the expansion of state Medicaid programs became voluntary. The effect is that at least by January 2014 half the states had decided not to expand Medicaid eligibility in their states.

Most of the other litigation has involved the contraception mandate, the requirement under the ACA that employers offer health insurance that includes basic preventive health benefits at no extra charge, including coverage of certain family planning services, to their employees. On March 25, 2014, the U.S. Supreme Court heard arguments in Sebelius v Hobby Lobby. The Court's decision, expected in late June or early July, will determine if the Religious Freedom Restoration Act of 1993 (RFRA) allows a for-profit corporation to deny its employees the health coverage of contraceptives to which the employees are otherwise entitled by federal law based on the religious objections of the corporation's owners.

Examples of decisions issued by courts in cases not involving the contraception mandate include:

- ***Halbig v Sebelius***, January 15, 2014. The District Court for the District of Columbia held that the ACA clearly supports an IRS regulation allowing the agency to issue premium tax credits to individuals enrolled through both federal and state Health Insurance Exchanges. The four individuals who

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brought the lawsuit challenged tax credits for ACA coverage in the 36 states with federal-run Exchanges, contending that the ACA only allows for state-run Exchanges to access the tax credits and Congress purposefully designed the law that way to incentivize states to run their own insurance Exchanges. On March 25, 2014, the D.C. Circuit Court of Appeals will consider the decision.

- ***Association of American Physicians and Surgeons, Inc. v Koskinen***, March 18, 2014. The District Court for the Eastern District of Wisconsin determined that an association of practicing physicians lacked standing to bring an action challenging the IRS' failure to implement the ACA's employer mandate.
- ***Chemence Medical Products, Inc. v Medline Industries, Inc.,*** December 4, 2013. Chemence Medical Products, Inc., a manufacturer of medical adhesives, was denied its request for a declaratory judgment finding that the ACA's medical device tax should be assessed against Medline Industries, Inc., a product distributor. The Northern District of Georgia granted Medline's motion for partial judgment on the pleadings, reasoning that absent any further agreements within Chemence and Medline's written contract, the ACA implies that, in this case, Clemence, the manufacturer is liable for the medical device tax.
- ***King v Sebelius***, February 18, 2014. The Eastern District of Virginia denied the motion for summary judgment of four Virginians who alleged that the regulation that extends premium assistance subsidies under the ACA exceeds the IRS' statutory authority. In upholding the regulation, the court dismissed the Virginians' complaint citing legislative history that shows deference was granted to the IRS in its interpretation of the word "Exchanges."
- ***Covenant Medical Center, Inc. v Sebelius***, January 30, 2014. Reopening a closed cost report was found not to be mandatory despite the existence of a pending appeal at the time of the enactment of the ACA. A federal district court clarified an ACA provision, which stated the changes arising from the ACA would only apply to cost reports after July 1, 2010, unless a jurisdictionally proper pending appeal was in place as of the date the ACA was enacted.
- ***St. Louis Effort for Aids v Huff,*** January 23, 2014. The court granted a preliminary injunction prohibiting the Director of the Missouri Department of Insurance from enforcing Missouri's Health Insurance Marketplace Innovation Act (HIMIA) as it applies to entities and individuals certified under federal law to provide services or perform functions pursuant to the ACA. The court concluded that St. Louis Effort for Aids and Planned Parenthood are likely to prevail on their claim that HIMIA is preempted to the extent that HIMIA applies to federally-approved Navigators, Certified Application Counselors (CACs) and Counselor Designated Organizations (together, federal counselors).
- ***State ex rel. Cleveland Right to Life v. State of Ohio Controlling Board***, December 20, 2013. When the Ohio Controlling Board approved the state Department of Medicaid's request for increased appropriation for the Hospital Care Assurance Match Fund, it did not exceed its statutory authority to approve requests for federal funding. The enacted statute does not forbid funding the expansion of the Ohio Medicaid program, and the Controlling Board exercised its discretion in approving the request.

...almost 150 federal district and appellate court decisions relating to the ACA have been issued since 2010

State-Level Litigation

In addition to action at the federal level, there have been some lawsuits filed, though no significant decisions issued, at the state level. The most significant issue at the state level involves health providers contesting being left out of a provider network of a health insurance plan offered though the state or federal Marketplace (STRATEGIC PERSPECTIVES: Hospital lawsuits over exclusions from ACA marketplace underscore need for wider networks,(Feb. 19, 2014)). Seattle Children's Hospital filed what is believed to be the first lawsuit over narrow provider networks after two health plans failed to include it in their networks. In New Hampshire, Anthem Blue Cross Blue Shield is the only insurance carrier that had joined the Marketplace by February 2014, and it did not offer a contract to Frisbie Memorial Hospital and nine other hospitals in the state. Frisbie filed a request for special hearing with the state's Department

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of Insurance, contending that it would lose revenue and be at a competitive disadvantage as compared to other medical providers because it is not part of Anthem's Marketplace network. Eleven hospitals in Kentucky also filed suit in state court after they were excluded from Kentucky's Health Insurance Exchange, Kynect.

At the end of January 2014, a Missouri district court entered an order and opinion granting a preliminary injunction of the enforcement of the Missouri Health Insurance Marketplace Innovation Act of 2013 (HIMIA) (Mo. Rev. Stat. sections 376.2006-376.2014). Specifically, the court granted the injunction to enjoin enforcement of the Missouri law insofar that it limits the role of entities and individuals that are certified to perform navigator services under the ACA because it found that HIMIA was likely to be preempted by the federal law with respect to those federally certified entities. In other words, HIMIA went too far to limit the role of the navigator and impinged on what the federal law explicitly provided for in terms of duties of the navigator (see STRATEGIC PERSPECTIVES: Recent challenges to state laws regulating navigators—policy or politics? (Part 2),(Mar. 17, 2014)).

"Informal" Announcements Related to Implementation

Another category of actions taken by agencies related to ACA implementation that must be mentioned concerns the announcement of delays or changes to the ACA. Several times in the last year the Obama administration announced a delay or change in the ACA not by amending the law or issuing a regulation, but by sending out a press release or posting information on an agency blog. The Congressional Research Service has documented some of these "informal" announcements. For example, in July 2013, on the Treasury Department blog, the Administration announced that it was delaying until 2015 the ACA requirement that employers with at least 50 full-time equivalent employees provide health coverage for their full-time workers or risk paying a penalty. In November 2013, on the HHS blog, the Administration announced that the federally-facilitated SHOP exchange, which was supposed to be operational October 1, 2013, would not accept online enrollments for one year, until November 2014.

What Lies Ahead

In addition to the delayed implementation of the employer mandate, there are other parts of the law still to be implemented over the next few years. Just for 2014, the law requires the following—

- HHS to deliver certain reports to Congress this year, including recommendations for improving the identification of health care disparities for beneficiaries and a report on the effectiveness of the vaccine demonstration project.
- Long-term care hospitals, inpatient rehabilitation facilities, hospices, and inpatient psychiatric facilities to submit data on specified quality measures to receive a full market basket adjustment.
- Funding for various programs authorized under the ACA to end on September 30, 2014, unless extended by Congress.
- Payments under the new prospective payment system for federally qualified health centers to start October 1, 2014.
- Medicaid payment rates paid at 100 percent of the Medicare payment rates to primary care physicians who specialize in family medicine, general internal medicine, or pediatric medicine will end December 31, 2014.

Changes in the health system that will be enacted in 2015 and 2016 under the ACA include—

- The establishment of a value-based payment modifier for Medicare physician payments.
- The risk corridor program, designed to reduce the impact of potential adverse selection and stabilize the cost of health insurance in the individual and small group markets, sunsets at the end of 2015.
- The National Association of Insurance Commissioners must implement the revised standards for Medigap benefit packages by January 1, 2015.
- The value-based demonstration program that will be conducted for a three-year period at an appropriate number of critical access hospitals ends on March 22, 2015.
- Funding for training for mid-career public or allied health professionals ends September 30, 2015.
- Beginning October 1, 2015, incentives for applicable hospitals to reduce hospital-acquired conditions with respect to discharges will be equal to 99 percent of the amount of payment that would otherwise apply to hospitals in the top quartile of hospitals with hospital acquired conditions.
- The Patient Navigator Program will cease at the end of 2015.
- Beginning January 1, 2016, multiple states may join together to form Health Care Choice Compacts which are designed to facilitate the purchase of qualified health insurance across state lines.

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- The HHS Secretary must use competitively bid prices for durable medical equipment in all MSA areas by January 1, 2016.
- States must stop establishing nonprofit reinsurance entities by December 31, 2016.
- The risk corridor program, designed to reduce the impact of potential adverse selection and stabilize the cost of health insurance in the individual and small group markets, sunsets at the end of 2015.

Conclusion

The ACA is a complex law being implemented by multiple federal and state level agencies with mandates that touch millions of individuals and businesses. Although about 7 million people had purchased insurance though a Health Insurance Marketplace as the end of the first open enrollment period neared on March 31, 2014, the law also has remained extremely unpopular with a plurality of Americans. The Administration has shown that it is responsive to some of the criticisms of the ACA by delaying some of the mandates, such as the employer mandate, and extending some deadlines, in particular deadlines for individuals to sign up for coverage. On March 26, CMS announced that individuals who had started but not finished the enrollment process at HealthCare.gov by the end of open enrollment on March 31would be able to come back in April to finish the process.

The full effect of the law will not be felt for a few more years, as individuals, businesses, and health care providers continue to respond to the new ways of getting health coverage and getting paid for providing health services and products. In the meantime, expect a continual series of formal and informal updates from federal agencies as well as significant interpretations of the law from the federal courts, in particular from the U.S. Supreme Court this summer, as well as state courts.

The Administration has shown that it is responsive to some of the criticisms of the ACA by delaying some of the mandates

Searching for Law Changes

Much of the information in this article was obtained by using the **Health Reform Law Lookup** tool which is part of Wolters Kluwer's **Health Reform KnowlEDGE Center.** To do your own search of the laws affected by the ACA, open the **Health Reform KnowlEDGE Center** and click on "Show All" under the Tools heading on the left side. On the next page, click on **Health Reform Law Lookup**. Select any of the public laws or statutes listed on that page and then click "Go To Results." The results page lists amended and new statutes, the ACA section providing the statutory language, a summary of the law, and an effective date.

To look at sample searches for different laws, click on one of the Acts listed below—

Social Security Act
Public Health Service Act
Employee Retirement Income Security Act
Food Drug and Cosmetic Act
Internal Revenue Code

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