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The Affordable Care Act at Age Five: A Look Back and A Look Ahead

Inside

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Executive Summary

Somewhere near their first birthdays, children learn to walk. At three years of age, they might start pedaling a tricycle, and at age five, they are poised to enter kindergarten. March 23, 2015, marks the fifth anniversary of the enactment of President Obama's signature health reform law, the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Has the ACA, at five years of age, made the same amount of progress as a child?

Critics argue that the ACA has failed, but proponents say that it is moving closer to achieving its goal of quality, affordable health care for all Americans. As a law that seeks to expand health insurance coverage for Americans, improve the functioning of health insurance markets, and control the efficiency and quality of health care, the ACA has "had a major positive impact, and one that will continue to bring efficiencies over time," said Keith Fontenot, the managing director of government relations and public policy at Hooper, Lundy & Bookman, P.C.

Regardless of whether it has met its milestones, it is clear that the ACA has already made an impact. It has had significant effects on the uninsured rate, the affordability of coverage via the provision of subsidies, the use of preventive services, and the actions of large employers and insurers. Many ACA provisions have gone into effect over the last five years; however, due to design or delay, a number of significant reforms have yet to be implemented or fully realized.

This White Paper looks at the ACA's impact on Medicare and Medicaid issues and its impact on the private insurance market. It also looks at major ACA changes facing health care providers and employers in the coming months.

Top 5 Medicare, Medicaid Issues

This section details five of the top health reform issues relating to Medicare and Medicaid: (1) the expansion of Medicaid; (2) the shift to value based purchasing; (3) the focus on readmissions reduction; (4) extension of the Medicare Trust Fund; and (5) the "death panel" controversy.

1. Medicaid Expansion

Section 1331 of the ACA sought to expand Medicaid eligibility to all adults under age 65 with income at or below 133 percent of the federal poverty level. The Supreme Court, however, held in *National Federation of Independent Business v. Sebelius* (2011) (*NFIB*) that the federal government could

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not force states to expand their Medicaid programs by conditioning federal funding on expansion. Because of this decision states can choose not to expand Medicaid, to expand Medicaid using the eligibility set by the ACA, or to expand Medicaid under a Section 1115 waiver—a choice that has become popular in states with leaders opposed to the ACA.

So far, the results of Medicaid expansion have been mixed, but with increased enrollment being the most notable effect (see *States' Medicaid enrollment increases regardless of expansion choice*, January 16, 2015). According to Donna Fraiche of Baker, Donelson, Bearman, Caldwell & Berkowitz, chair of the Louisiana Health Care Commission, states that chose to expand Medicaid have experienced a drop in overall premium costs for all, increased use of primary care, a drop in emergency room use, and innovative new programs and state waivers. However, states have also seen more crowding in hospitals and doctors' offices and less access because of the lower rates paid to providers under Medicaid, as well as narrower provider networks.

"While coverage has increased markedly, it is falling far short of the goal originally envisioned by the law mostly because of the Supreme Court decision regarding Medicaid," Fontenot said. "Over the long run, I believe more and more states will gradually opt into Medicaid, but it could take a number of years. We should remember that it took a number of years before some states opted into Medicaid when first enacted in 1965."

Unexpected challenges. "The major shift in Medicaid eligibility related to the ACA came with the Supreme Court decision that made the expansion of coverage optional for states. In spite of the federal government covering 100 percent of the cost in the short term, and despite strong support from providers and others, many states have in the short term decided not to expand the program," Fontenot said. As a result, in states that did not expand Medicaid, "childless adults with income above 100 percent of poverty may get coverage through the new marketplaces but coverage for those below 100 percent is sparse."

Louisiana, for example, was the first state to refuse to expand Medicaid. Fraiche said that Medicaid enrollment was expected to increase because of the ACA's individual mandate. The state's poorest citizens, however, were already covered by Medicaid, and those who remained ineligible because of Louisiana's choice not to expand "were not mandated to nor did not perceive that they were able to afford any form of commercial insurance or access the exchange. Thus, hundreds of thousands of people who were contemplated to be able to come into the system [under Medicaid expansion] lack coverage."

State innovation waivers. Fontenot noted that the Supreme Court decision to make Medicaid expansion optional "open[ed] the door to alternative approaches that might not have gained traction but for the Court's decision. In some cases, states have sought to expand the program but to modify it in some way to make it more acceptable to those in the state that might be opposed to expanding Medicaid. Arizona was the leader in this area, using Medicaid funds to pay private coverage through the health insurance marketplace. Other states have sought and received waivers that would put additional requirements, such as premium payments, on the new Medicaid recipients."

Issues associated with adding new eligibility groups to Medicaid are largely known and have been experienced in the past, such as budgeting for the coverage of new groups and determining the adequacy of provider reimbursement. "The really new, unexpected issues are likely to arise more in the case of waiver states rather than in states that have followed the traditional path," he said. "In the case of innovative programs such as Arizona's [in which adults without dependent children and with income levels between 0 and 100 percent of the federal poverty level receive expanded eligibility], there have been some questions, for example, with how premiums compared to projections, which appear to be explained by a few basic factors and don't seem to represent a trend. Otherwise the news has been good—uninsured rates and uncompensated care are both down."

2. Value-Based Purchasing and Accountable Care Organizations

Traditionally, Medicare operates as a fee-for-service system under which providers are reimbursed—regardless of the outcome—for each service provided. The National Commission on Physician Payment Reform said in March 2013 that "the fee-for-service mechanism of paying physicians is a major driver of higher health care costs in the U.S. It contains incentives for increasing the volume and cost of services, whether appropriate or not; encourages duplication; discourages care coordination; and promotes inefficiency in the delivery of medical services."

Quality over quantity. In early 2105, HHS Secretary Sylvia Burwell announced that HHS had updated its goals for transitioning Medicare from fee-for-service to a value-based system of provider payments, stating that, by 2016, CMS would like 30 percent of providers to use alternative payment models emphasizing quality

over quantity, with 85 percent of Medicare payments being tied to quality or value (see *Goals and timeline set for achieving value-based Medicare reimbursement*, January 28, 2015). These goals are in line with the incentives set by the ACA with a focus on value-based purchasing (described under Section 3001 of the ACA), including the creation of the Medicare Shared Savings Program (MSSP) under Section 3022 of the ACA, and the establishment of the CMS Innovation Center under Section 3502 of the ACA, which created the Bundled Payments for Care Improvement Initiative (BPCII), which tests bundled payment arrangements combining financial and performance accountability (see *Toward value-based payments: Can CMS deliver on goals?*, February 19, 2015).

Accountable care organizations. Created under the MSSP, accountable care organizations (ACOs) are groups of doctors, hospitals, and health care providers who join voluntarily to provide high-quality coordinated care to Medicare beneficiaries. Cost and quality are inherently tied in the payment system of ACOs, which are required to report quality measures such as readmissions, use of electronic health records (EHR), and preventive care and screening for various health issues to CMS (see *Focus on quality, coordination of care leads to quick changes for U.S. health care delivery*, March 19, 2014). In October 2014, CMS reported that ACOs were eligible for $455 million in incentive payments under the MSSP, with the Medicare program saving $372 million during the MSSP's first year (see *ACOs receive shared savings payments*, September 24, 2014).

3. Readmissions Reduction

ACA Section 3025 created the Medicare Hospital Readmission Reduction Program (HRRP), which was developed in response to concerns that hospitals receiving payments under fee-for-service Medicare were experiencing a high volume of readmissions, defined as an admission within 30 days of discharge from the same or another inpatient prospective payment system (IPPS) hospital. The HRRP imposed a penalty in the form of reduced payments to hospitals with excessive readmissions (see *IPPS admission and readmission standard doesn't 'measure' up*, December 20, 2014). In June 2014, members of Congress sent a letter to HHS expressing concerns about flaws in the HRRP penalty methodology, noting that some hospitals were being unfairly penalized because of factors outside of their control and regardless of the quality of care being provided (see *Hospital readmission penalties need change*, June 18, 2014).

According to CMS estimates, two million patients are readmitted each year at a cost of $26 billion—with $17 billion coming as a result of potentially avoidable readmissions. In the last year, data showed that, of all the Medicare beneficiaries hospitalized, nearly 18 percent were readmitted within the month. Penalties resulting from the HRRP totaled $428 million in 2014, spread among a record 2,610 hospitals. The penalties are to be paid between October 1, 2014, and September 30, 2015. These penalties ranged from one hundredth of a percent to 3 percent (see *More than 2.5k hospitals docked for excess readmissions*, October 8, 2014).

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> — Keith Fontenot, Managing Director Government Relations and Public Policy, Hooper, Lundy & Bookman, P.C.

Medicaid readmissions. Adult Medicaid patients have the highest readmission rates of any payer, according to the Agency for Healthcare Research and Quality (AHRQ) at CMS. Because of Medicaid expansion, the AHRQ stated that the new population of patients seeking care will include those with very little health care experience and will be younger than the usual Medicare beneficiary. Thus, the readmission reduction practices of the Medicaid program—which generally serves an older population with a different set of health issues—do not meet the needs of new Medicaid patients. In response to this issue, the AHRQ issued its Hospital Guide to Reducing Medicaid Admissions, which provides suggestions for improving transitional care strategies to better meet the needs of this new group (see *Finally, hospital readmissions guidance that focuses on Medicaid*, September 3, 2014).

4. Medicare Trust Fund

As a result of the higher efficiency in health care spending attributable to the ACA's focus on quality over quantity, Medicare's trustees projected that the Medicare Trust Fund assets will be depleted in 2030 rather than 2026, as it previously reported. According to the trustees, three factors played a role in extending the life of the Medicare Trust Fund: (1) slower than projected spending in 2013; (2) lower than expected utilization of inpatient hospital services; and (3) lower than anticipated increase in case mix (see *Life expectancy of Medicare trust funds extended to 2030*, July 30, 2014).

These findings contradict claims by some policymakers that the Medicare program is on its way to "bankruptcy," said Paul N. Van de Water, a senior fellow at the Center on Budget and Policy Priorities. "Medicare's financing challenges would be significantly greater without the health reform law . . ., which substantially improved the program's financial outlook," he added. The findings by Medicare's trustees that the ACA has improved Medicare's financial outlook "is consistent with the Congressional Budget Office's estimate that health reform will reduce federal budget deficits—modestly in its first ten years, but substantially in the following decade."

Referencing the 2014 trustee report, Van de Water noted that the 2030 date given does not apply to Medicare coverage for physician and outpatient costs, nor does it apply to Medicare prescription drug benefits, which "do not face insolvency and cannot run short of funds," as they are financed through the Supplementary Medical Insurance (SMI) trust fund. "The SMI trust fund always has sufficient financing to cover Part B and Part D costs because the beneficiary premiums and general revenue contributions are specifically set at levels to assure this is the case," he said. "SMI cannot go 'bankrupt.'"

5. The "Death Panel"

Prior to the signing of the ACA, word began to spread that the health reform bill contained a provision giving a government panel—dubbed the "death panel"—the ability to make decisions regarding Medicare beneficiaries' end-of-life care. While no such provision made it into the law, the death panel myth was influential in shaping Americans' perceptions of the ACA, with 60 percent of Americans responding to a 2013 poll saying they believed or were unsure whether death panels were part of the ACA (see *Advance care planning proposals: Confronting the ACA 'death panel' myth*, October 17, 2014).

While nothing like a death panel ended up in the ACA, the rhetoric was so powerful that opponents of the ACA kept the label and applied it to a different provision of the health reform law—the Independent Payment Advisory Board (IPAB). Created under Section 3404 of the ACA, the IPAB was to consist of a 15-member board of experts in disciplines such as health finance and economics, actuarial science, and health care reimbursement. Section 3404 sought to give the board the authority to hold hearings and make recommendations to Congress on which changes should be implemented to maintain or enhance beneficiaries' access to health care. The ACA banned the IPAB from recommending to ration health care, raise revenues or premiums, increase beneficiary cost-sharing, restrict benefits, or modify eligibility criteria. As of the date of the publication of this Strategic Perspective, no experts have been nominated to serve on the IPAB and no meetings have been held.

Coons v. Lew. One challenge to the ACA alleged that the IPAB violates Article I of the Constitution's nondelegation principle. The challenge was found to be unripe, however, as it rested on the notion of potential future reductions to the Medicare budget (see *Another ACA attack dies; ripeness and preemption deal the death-blow*, August 13, 2014). Republicans filed an amicus brief asking the Supreme Court to hear *Coons v. Lew*, arguing that the ACA creates an unconstitutional agency with "uncontrollable and unreviewable" powers that could dramatically alter Medicare reimbursement (see *Republicans file amicus brief over so-called 'death panel'*, December 10, 2014). The Supreme Court has yet to make any decision on the fate of the IPAB.

Top 5 Areas of Progress

This section details five of the top health care reform issues related to the private health insurance market: (1) the impact of the ACA on the uninsured rate; (2) making health insurance more affordable through subsidies and tax credits; (3) coverage of preventive services; (4) issues relating to large employers; and (5) how insurers have been affected.

1. Uninsured Rate

In 2010, less than a week before the ACA became law, Gallup announced that the adult uninsured rate for January and February of 2010 was 16.2 percent. Fewer people were receiving insurance through an employer than in 2008, and more were relying on government

coverage. The rate fluctuated for years, reaching a high in mid-2013 of 18.6 percent; Gallup noted a December 2013 rate of 17.3 percent.

The individual mandate went into effect in 2014. The first open enrollment period to secure coverage via the Health Insurance Marketplace began in October 2013, with coverage being active as early as January 1, 2014. Medicaid expansion in some states also kicked in during January. By mid-February, the uninsured rate had dropped to 16 percent, its lowest since 2009. In April, it reached a record low of 13.4 percent. The fourth quarter of 2014 averaged 12.9 percent, a decrease of 4.2 percentage points since the individual mandate went into effect.

Can these decreases be attributed to the ACA? Gallup thinks so, stating that the ACA has accomplished its goal of increasing the percentage of Americans with health insurance coverage. States that opted to both (1) implement a state-based or partnership Exchange and (2) expand Medicaid saw the most significant decreases in the uninsured rate since the mandate took effect. The uninsured rate dropped 4.8 points in the 21 states that implemented both of these measures, compared to 2.7 points in the 29 states that implemented neither or only one of these measures (see *States with Medicaid expansion, Exchanges saw greatest drop in uninsured*, February 25, 2015). Massachusetts, the state with the lowest uninsurance rate, underwent its own health care reform in 2006, many aspects of which were preserved in the ACA. In August 2014, Gallup noted that Arkansas, Kentucky, and California, three states that were formerly among the ten states with the highest uninsured rates, appeared among the ten states with the highest reduction in uninsured rates.

Katherine Hempstead of the Robert Wood Johnson Foundation estimates that Medicaid expansion "has accounted for the biggest share of coverage growth" among the estimated 10 million people who have gained coverage since the passage of the ACA. One quarter of the estimated 36 million people remaining uninsured are Medicaid-eligible, but live in states that did not expand Medicaid. Hempstead believes that all states will eventually expand Medicaid, which could lead to an uninsurance rate as low as 5 percent by 2020. She notes that roughly one-quarter of the uninsured are ineligible due to immigration status. The remaining 50 percent remain uninsured despite being eligible for coverage through Medicaid, an employer, or the Marketplaces; many cite affordability of coverage as a concern.

A report published in the New England Journal of Medicine analyzed data from the Gallup polls and compared it with HHS enrollment statistics for Medicaid and Marketplace coverage in each state during the 2013-2014 open enrollment period. The study noted a 5.2 percentage point drop in the uninsured rate, as compared to the baseline trend, by the second quarter of 2014, which it deemed a significant decline that was "consistent with the broad pattern" noted in the Gallup polls. As an observational study, however, it could not attribute the decline to the ACA, but could "only identify suggestive associations between the ACA, the declining uninsured rate, and access to care," (see *Uninsured rate decline confirmed to 'coincide' with ACA, data limitations highlighted*, September 3, 2014).

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2. Subsidies and Tax Credits

The ACA sought to make health insurance more affordable to individuals both through subsidies available to income-eligible consumers purchasing insurance coverage via the Marketplace and through premium tax credits. Have consumers taken advantage of those subsidies? How effective have they been? Are those monies in danger?

Cost-sharing subsidies. The Marketplace offers plans at four tiers--bronze, silver, gold, and platinum—as well as; it also offers catastrophic coverage. The plans have varying actuarial values, which are the cost of covered services that a plan must pay on average for a typical group of enrollees. Bronze plans, which have the lowest actuarial value, carry the least expensive premiums, but the highest out-of-pocket expenses; conversely, platinum plans, which have the highest actuarial value, carry high premiums, but low out-of-pocket costs.

Standard silver plans have an actuarial value of 70 percent. Section 1402 of the ACA, as amended by section 1001 of the Health Care and Education and

Reconciliation Act (HCERA) (P.L. 111-152), requires insurers to offer reduced levels of cost sharing to low-income individuals purchasing silver-level plans through an Exchange. These subsidies are available in the form of variations on the silver plan that allow the actuarial values to increase to 73 percent for those people with incomes between 200 and 250 percent of the federal poverty level (FPL), 87 percent for people with incomes between 150 and 200 percent of the FPL, and 94 percent for people with incomes less than or equal to 150 percent of the FPL. They are only required for services provided by in-network providers. A Kaiser Family Foundation (KFF) study found that subsidies made significant differences in the amount of money that individuals might owe. For example, the $5,824 average out-of-pocket cost for standard silver plans for single coverage in 2015 is reduced to $879 for those earning less 150 percent of the FPL. The maximum out-of-pocket limit for single coverage is reduced from $6,600 to $2,250 for people with incomes less than 200 percent of the FPL (see *Exchange subsidies make a big difference to small incomes*, February 18, 2015).

Premium tax credit. Section 1401 of the ACA added section 36B to the Internal Revenue Code and created the premium tax credit, an advanceable and refundable credit that eligible consumers may use toward payment of their premiums on Exchange plans. To qualify, consumers purchasing a Marketplace plan must not be eligible for coverage through a government program or for affordable coverage through an employer plan that provides minimum value and must have a household income between 100 and 400 percent of the FPL. The credit is calculated on a sliding scale so that people with lower incomes receive higher credits than those with higher incomes. If the credit is advanced and it is later determined that the allowable credit was less than the amount of the credit advanced, the consumer will need to refund that money to the IRS; if a credit is more than the amount of a consumer's tax liability, he or she will receive the difference as a refund.

According to KFF and the Journal of the American Medical Association, the tax credits do make premiums more uniform across income groups. The authors noted great variation in monthly premium changes from 2014 to 2015 for a 40-year-old individual covered by the second-lowest cost silver benchmark plan. When a tax credit was applied to a 40-year-old earning $30,000 per year, however, the changes became practically flat, generally increasing or decreasing by only 1 percent (see *Tax subsidies' dramatic effect shown in infographic, worth a thousand words*, February 18, 2015).

King v. Burwell. The application of the premium tax credit is the subject of *King v. Burwell*, a case pending before the U.S. Supreme Court. The King plaintiffs are challenging the IRS' application of the premium tax credit to individuals who purchase insurance through HealthCare.gov, arguing that section 1311 of the ACA, which refers to an "Exchange established by the State," only authorizes the application of the credit to individuals who purchase insurance through a state-based Exchange (see *SCOTUS hears King v. Burwell: Kennedy voices constitutional concerns, Roberts doesn't tip his hand*, March 11, 2015).

The case is politically charged. Although a ruling for the plaintiffs would not invalidate the entire ACA, it would affect subsidies for six million Americans, dramatically impacting the ACA's goal of making affordable coverage available to all Americans. The U.S. Court of Appeals for the Fourth Circuit ruled for the government in an earlier incarnation of the case. One policy expert noted that the Supreme Court granted the King plaintiffs' petition for certiorari despite the absence of a circuit split, as a ruling against the government in *Halbig v. Burwell* was awaiting en banc review before the U.S. Court of Appeals for the District of Columbia (see *Policy wonk gives conference-goers the nitty-gritty on the ACA*, November 25, 2014). HHS Secretary Burwell maintains that the Obama Administration is confident that the government will prevail and believes that no actions could "undo the massive damage to our health care system that would be caused by an adverse decision," (see Burwell: *No remedy for 'massive damage' adverse King ruling would cause*, March 4, 2015).

3. Preventive Services

The most notorious and controversial provision of the ACA is likely the imposition of the contraception mandate, which requires employers with 50 or more employees to offer health plans that cover FDA-approved contraceptive services. The contraception mandate is part of the larger preventive services provision of the ACA, which has had a significant, if less visible, impact. What effect has Supreme Court litigation had on the contraception mandate? Have Americans taken advantage of other preventive services without cost sharing?

Contraception mandate. Section 1001 of the ACA amended section 2713 of the Public Health Service Act (PHSA) to require group health plans and issuers to cover four categories of preventive services. Two of these categories relate to contraceptives: (1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF) and (2) with

respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The HRSA added all FDA-approved contraceptives to its guidelines based upon recommendations in a report issued by the Institute of Medicine. HHS adopted the HRSA list in a 2011 Final rule (76 FR 46621, August 3, 2011). Religious employers eventually were exempted from the requirement; however, nonprofit religious organizations and for-profit companies with religious leanings continued to litigate the issue.

In *Burwell v. Hobby Lobby*, a case involving a for-profit employer, the U.S. Supreme Court ruled that the contraceptive mandate regulations violated the Religious Freedom Restoration Act (RFRA), which prohibits the federal government from substantially burdening a person's religious freedom unless the burden serves a compelling interest and is the least restrictive means of furthering that interest. The Court rejected the government's arguments that the corporate employers were separate from their owners and that for-profit organizations do not "exercise religion" (see *Closely-held 'corporate Christians' win crusade against contraceptive coverage*, July 2, 2014).

The government previously created an accommodation for nonprofit religious organizations that did not qualify for complete exemption from the mandate by permitting them to submit Employee Benefits Service Administration (EBSA) Form 700 to HHS, which states that the organization has a religious objection to the mandate. The organizations would then need to submit copies of the form to their plans' health insurer or third party administrator. One week after issuing the *Hobby Lobby* decision, the High Court granted an injunction to Wheaton College, a Christian liberal arts college, enjoining the government from requiring Wheaton to execute EBSA Form 700, which Wheaton believed would "make it morally complicit in the wrongful destruction of human life." In doing so, the Court noted the existence of a circuit split as to whether to enjoin the requirement that religious nonprofit organizations use EBSA Form 700 (see *Supreme Court: religious college doesn't have to file contraception mandate opt-out form*, July 9, 2014).

As a result, HHS, the IRS, and the EBSA issued an interim final rule giving religious nonprofits an alternative to the EBSA 700 requirements (see *Employees still protected, Feds provide birth control*, Aug. 27, 2014). The interim final rule provides that instead of executing EBSA from 700, an organization may write to the HHS Secretary, notifying her "that it is a nonprofit organization that holds itself out as religious and has religious objections to providing coverage for contraceptive services." At that point, the government will notify the health insurer or third party administrator of its obligations to provide contraceptive coverage to the organization's employees. The government hoped that this would address organizations' concerns that they were actively facilitating the provision of contraception; however, some organizations continue to object to the requirement, arguing that they still appear to condone wrongdoing.

The number of women who filled prescriptions for oral contraceptives without a copay more than quadrupled from 1.2 million in 2012 to 5.1 million in 2013.

Provision of contraceptive services. The preventive services coverage provision was effective for nongrandfathered plan years beginning on or after September 23, 2010; thus, it was generally effective beginning in 2011. It was effective for women's clinical preventive services for nongrandfathered plan years beginning August 1, 2012, making that portion effective by 2013.

Women are reaping the benefits of the contraception-related provisions of the ACA. According to an issue brief published by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) the number of women who filled prescriptions for oral contraceptives without a copay "more than quadrupled from 1.2 million in 2012 to 5.1 million in 2013;" the number of prescriptions increased from 6.8 million to 31.1 million. There have been reports, however, of errors at pharmacies dispensing oral contraceptives. For example, CVS Health was put on notice by a congressional representative that it had been charging copays for generic contraceptives due to a common drug price coding error. CVS eventually acknowledged the error, refunded money to 11,000 women who had been affected, corrected the error, and authorized its pharmacists to escalate future coding problems for immediate correction (see *CVS refunds generic copays that violated ACA*, October 1, 2014).

Other preventive services. The contraceptive mandate is only a small portion of the ACA's preventive services provisions. The USPSTF as of October 2014 had assigned A and B ratings to 55 services, ranging from one-time abdominal aortic aneurysm screening in men ages 65 to 75 who have ever smoked, to visual acuity screening in children at least once between the ages of three and five years to detect the presence of amblyopia (lazy eye) or its risk factors. The preventive care and screenings supported by the HRSA include breastfeeding support, supplies, and counseling, annual well-woman visits, and domestic violence counseling. The ACA also includes two additional categories of preventive services: (1) immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) for specific individuals and (2) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings supported by the HRSA. The cost-sharing waivers are subject to limitations imposed by an interim final rule; for example, they only apply to services provided by in-network providers (75 FR 41726, July 19, 2010). In addition, insurers may exercise "reasonable medical management techniques" when regulations do not specify the frequency, method, treatment, or setting for the provision of a covered service. Because the term is not defined, plans interpret it differently (see *Out of the spotlight, stakeholders work through ACA preventive services kinks*, November 25, 2014).

4. Large Employers

Section 1513 of the ACA requires employers with 50 or more full-time equivalent (FTE) employees to offer at least 95 percent of their employees minimum essential health coverage that is affordable. Employers that fail to do so will be forced to pay one of two types of shared responsibility payments. Those that do not offer qualified health insurance and have at least one employee receiving a tax credit for insurance through an Exchange are subject to a $2,000 penalty for each FTE in excess of the first 30. Employers that offer insurance that fails to meet an affordability standard must pay a penalty for every employee who receives a tax credit to purchase coverage through an Exchange. This penalty will equal the lesser of (1) $3,000 per employee who receives subsidized coverage in the Exchange or (2) the penalty tax the employer would have to pay if it did not offer health insurance. Large employers were understandably concerned when the law passed. Even as implementation has been delayed, employers are taking steps to comply and lobbying for changes.

Delays. The law was originally intended to take effect on January 1, 2014, but the IRS announced that it would not take enforcement action until 2015. Later, it extended the deadline for compliance for employers with 50 to 99 employees to January 1, 2016. It also stated that employers need only offer coverage to 70 percent of their full-time employees in 2015, as opposed to 95 percent in 2016 and beyond (see *IRS issues final employer shared responsibility regulations along with significant new transition relief*, February 11, 2014). Speaker of the House John Boehner filed a lawsuit on behalf of the House against HHS Secretary Burwell, alleging that the Administration's delay was unconstitutional (see *President's 'unilateral actions' draw strong reaction: GOP sues Obama*, November 25, 2014). The litigation is pending.

Full-time definition. The ACA defines a full-time employee as one who works an average of 30 hours per week. Critics of the provision maintain that it encourages employers to limit the hiring of full-time workers or cut their hours and limit the hours of part-time workers. Low-wage employers that have not offered health insurance coverage in the past, as well as school districts that employ various part-time employees and institutions of higher education that employ adjunct faculty, are likely to be affected. The Save American Workers Act of 2015 (H.R. 30) and the Forty Hours Is Full Time Act (S. 30), lobbied for by the retail, restaurant, and hotel industries, would change definition of full-time to 40 hours per week (see *Unintended consequences of the ACA's 30-hour work week*, February 18, 2015).

Skinny plans. In an effort to minimize expenses while meeting minimum value requirements, some employers considering offering "skinny" plans that offered the required 60 percent minimum value standard, but excluded inpatient hospital benefits. HHS put a stop to this in a recently issued final rule in which it made clear that plans will not meet minimum value standards requirements unless they include "substantial coverage" of inpatient hospital services and physician services and other benefits that have been historically provided under major medical coverage (80 FR 10750, February 27, 2015). The rule noted that employers who have saved money by offering plans without such coverage are circumventing the purpose of the minimum value requirements.

5. Insurers

Insurers were one of the first groups to be affected by the ACA, with rate review and medical loss ratio (MLR) provisions going into effect in 2011. The public nature of the rate review process and the notification to consumers involved in the MLR reporting brought them to the public forefront.

Rate review. State insurance departments previously reviewed insurers' requests to increase policy rates to ensure that they are based on accurate data and projected costs, but laws were not uniform. Section 1003 of the ACA, which added section 2794 of the PHSA, requires states to review all requested rate increases of 10 percent or more to determine whether they are reasonable and requires insurers to publicly justify the increases. States then have the authority to approve or disapprove the requests or require the health plan to use a lower rate. Before states conduct their review, insurers must issue disclosures to consumers notifying them of the products affected, the average dollar increase and resulting monthly rate, the range of percentage increase based on individual factors, the effective date of the new rate, and the number of people affected in the state.

According to HHS' September 2014 annual rate review report, rate increases were reduced by 8 percent in 2013 for all 40 states that were examined, resulting in a $290 million reduction in premiums in the individual market. Premiums were reduced by an estimated $703 million in the small group market thanks to a reduction in the average requested rate increase of 11 percent for the 37 states examined. A KFF analysis found that one out of every five rate review requests submitted in 2011 were denied or resulted in a lower rate increase (see *Reviewing the ACA's rate review program*, August 13, 2014).

Medical loss ratio. The MLR provision of the ACA requires insurance companies in both the individual and small group markets to use 80 to 85 percent of their collected premiums toward claim payments or quality improvement activities; if less than that percentage is allocated to those areas, the difference must be issued to consumers in the form of rebates. Although critics worried that the requirement could affect market stability, the MLR does not seem to be causing insurers to leave markets. Proponents believe that it results in better value for consumers and increased transparency. According to Wake Forest University Law Professor Mark Hall, consumers gained $1.1 billion in health insurance rebates in 2011. In 2012, rebates dropped by approximately half, to $513 million, suggesting that insurers were spending their money more appropriately (see *MLR has produced positive results so far, Wake Forest law professor testifies*, June 4, 2014).

Top 5 Looming Changes for Providers, Individuals, and Employers

This section looks to the future, and focuses on five major ACA changes to look forward to in the coming months: (1) the employer mandate and shared responsibility payments, known as "pay or play"; (2) recordkeeping requirements for employers; (3) the hospital-acquired condition (HAC) reduction program; (4) tax penalties for individuals who did not have health insurance during 2014; and (5) reductions in the Medicaid disproportionate share hospital (DSH) payment rate.

The employer mandate subjects large employers to assessable shared responsibility payments if one or more of its full-time employees receive a health insurance premium tax credit or cost-sharing reduction when obtaining coverage on a Health Insurance Exchange.

1. Pay or Play

Beginning in 2015, applicable large employers (ALEs) that are subject to the Code Section 4980H rules for employer shared responsibility are required to report to the Secretary of the Treasury whether they offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and provide details regarding the coverage offered and other required information. This requirement has been nicknamed "Pay or Play," because employers are faced with the decision to either play along by complying with the employer mandate, or pay the penalty for noncompliance

(see *Employer Shared Responsibility Mandate—To Pay or Play? That is the Question*, June 2014).

Employer mandate. The employer mandate, as provided in section 1513 of the ACA, subjects an ALE to assessable shared responsibility payments if one or more of its full-time employees receive a health insurance premium tax credit or cost-sharing reduction when obtaining coverage on a Health Insurance Exchange. The IRS determines shared responsibility payments based on individual tax returns and information reported by ALEs and insurance providers for the particular period. The IRS will contact an affected employer, and the employer will have an opportunity to respond.

One of the most controversial provisions of the mandate is the ACA's definition of "full-time employee." In section 4980H, the ACA states, "The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week." Because of this definition, many critics of the law claimed that employers would shift employees to 29 hours of work or less each week to avoid having to pay for health insurance (see, e.g., *Unintended consequences of the ACA's 30-hour work week*, February 18, 2015; *ACA's 30-Hour Work Rule Draws Criticism at Ways and Means Hearing*, February 5, 2014; *Redefine full-time employee to 40 hours per week, hearing witnesses say*, February 5, 2014).

Most choose to play. Randall K. Abbott, senior consultant and North American Leader for Health and Group Benefits at Towers Watson, explained that employers with over 1,000 employees "typically meet the requirements for affordability and minimum plan value." Therefore, he said, that large employers "intend to play for the foreseeable future," because removing health benefits "is a major takeaway from a total compensation perspective." Tom Billet, senior consultant at Towers Watson, agreed, stating that large employers all offer health insurance to begin with and, therefore, "compliance is not an issue."

Both Abbott and Billet discussed workforce evaluations that ALEs have been performing to assure compliance. Abbott said that large employers have been determining "what actions they need to take to assure compliance with the 30-hour rule and have made necessary adjustments." He stated, "While this will require administrative effort and ongoing measurement, the requirements have been anticipated and planned for."

2. Employer Recordkeeping Requirements

To enforce the ACA's individual and employer shared responsibility requirements, ALEs must report to the Secretary of the Treasury whether they offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and provide details regarding the coverage offered and other required information. ALEs also must furnish each full-time employee with a written statement, detailing the contents of the reported information.

Delay. Section 1513 of the ACA requires employers with 50 or more full-time equivalent employees to offer their employees minimum essential health coverage. The law was originally intended to take effect on January 1, 2014; however, the IRS delayed enforcement of the employer mandate, making it applicable for plan years beginning after December 31, 2014.

Reporting requirements. On March 10, 2014, the IRS published two Final rules for information reporting. "Information Reporting of Minimum Essential Coverage" applies to providers of minimum essential health coverage (including employers with self-insured plans) under Internal Revenue Code (IRC or the Code) Section 6055 regarding the type and period of coverage (79 FR 13220), and "Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans" applies to ALEs under Code Section 6056 concerning health care coverage they offer to their full-time employees (79 FR 13231).

Large employers must now keep records on the number of full-time employees they have, as this information will be required to determine ALE status, coverage requirements, and certain penalty assessments. During a February 10, 2015, Tax Talk Today program, Kevin Knopf, a Treasury Office of Tax Policy attorney, stressed the importance of implementing an information collection system to determine the number of full-time and full-time equivalent employees. "For many employers, that could be easy," he said. "However, in some sectors of the economy, employees work variant hours." In such cases, Knopf said that employers must implement a different plan for determining who their full-time employees are by examining the employee's work hours during the look-back measurement period and stability period (see *Business taxpayers should review Form 3115 reporting, ACA requirements, experts say*, February 18, 2015).

Unprepared employers. A January 15, 2015, white paper from ADP announced that more than half of large employers (1,000+ employees) are unprepared to comply with all ACA regulatory requirements (see *More than half of employers feel unprepared to manage*

ACA compliance requirements, January 21, 2015). ADP's study revealed that while 70 percent of large employers handle ACA compliance internally, they do not feel fully prepared to manage some of the ACA's compliance requirements, including Exchange notices (62 percent), ACA penalties (60 percent) and annual health care reporting to the IRS (49 percent).

Juliette Meunier, from Ernst & Young's human capital practice, explained the necessity of early and ongoing preparation in an April 2014 webinar. "As I think about the IRS reporting that is due January 2016, it seems a ways off. However, when we look into the timeline that is going to be needed to gather that information, the first month that employers will have to gather information is January 2015. You must think about the systems that will be needed and implementing those systems," said Meunier (see *Employers need to concentrate on systems for ACA compliance now, say experts at Ernst & Young*, April 9, 2014).

3. Hospital-Acquired Condition Reduction Program

Starting in FY 2015, inpatient hospitals in the top 25th percentile of rates of hospital-acquired conditions (HACs) for certain high-cost and common conditions will be subject to a payment penalty under Medicare.

HACs. More than 1,000 people die each day from preventable medical errors. Health care-associated infections (HAIs) are infections that individuals acquire during the course of treatment for another condition in a health care setting. According to the Centers for Disease Control and Prevention (CDC), approximately one in 25 patients receive at least one infection during the course of their hospital care. Due to the high number of preventable deaths and injuries attributable to HACs, the ACA included a number of provisions to reduce such problems. Under section 3008, Medicare payments will be reduced by 1 percent to hospitals scoring in the top quartile of the national average for HACs. Section 3025 of the ACA also seeks to reduce hospital readmissions, which are associated with HACs, by reducing the base diagnosis-related group (DRG) payment to hospitals based on the ration of actual to expected readmissions. The CDC reports that the number of HACs and HAIs is decreasing, but seeks further progress.

Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from 1 to 10. The higher a hospital's Total HAC Score, the worse the hospital performed under the HAC Reduction Program. Hospitals have an opportunity to review their data and request a recalculation of their scores if they believe an error in the score calculation has occurred.

Criticism of HAC Reduction Program. The American Hospital Association's (AHA) Senior Associate Director of Policy, Akin Demehin, explained, "While we appreciate the goal of the HAC Reduction Program, it has a number of critical shortcomings that impede its ability to encourage continuous improvement and to fairly assess hospitals." Specifically, Demehin noted "the program is required to penalize 25 percent of all hospitals each year, regardless of significant performance improvement by individual hospitals or the field as a whole." In addition, "hospitals treating complex patients are disproportionately penalized," attributable in part to the HAC program's use of "claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details on a patient's risk factors and course of care." Demehin expressed concern that "overlap with the measures in the value-based purchasing (VBP) program," may cause "excessive payment penalties and confusion about the true state of hospital performance."

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>
> — Akin Demehin
> Senior Associate Director of Policy
> American Hospital Association

Despite these shortcomings, Demehin said, "the HAC Program absolutely has the right goal." He pointed to a nationwide reduction in 28 different HACs between 2010 and 2013, which "translates into an estimated 1.3 million fewer HACs over this period, which in turn has prevented an estimated 50,000 deaths and saved $12 billion."

4. Individual Mandate Penalties

April 15, 2015, is the deadline to file individual federal income tax returns with the IRS; for the first time, the ACA's individual shared responsibility provision is applicable, requiring individual filers to report health insurance coverage.

Shared responsibility. Section 1501 of the ACA requires individuals to maintain minimum essential coverage, which can be obtained through a variety of sources, including an employer, the Health Insurance Marketplaces, and Medicare or Medicaid. The individual shared responsibility provision of the ACA went into effect in 2014; individuals filing their 2014 tax returns must either report minimum essential coverage or make shared responsibility payments. For individuals making the shared responsibility payment, the annual payment amount is the greater of a percentage of household income or a flat dollar amount; for 2014, the annual payment amount is the greater of: (1) 1 percent of household income that is above the tax return filing threshold for the individual's filing status, or (2) a family's flat dollar amount, which is $95 per adult and $47.50 per child, limited to a family maximum of $285.

According to CMS, about three-quarters of taxpayers will only need to check a box on their 2014 return to indicate that they had qualifying health coverage in 2014. However, the remaining quarter of taxpayers will either need to qualify for an exemption or pay the shared responsibility fee. CMS estimates that 2 to 4 percent of taxpayers will pay the fee because they made a choice to not obtain coverage and are not eligible for an exemption.

Unaware filers. In a February 20, 2015, press release, CMS announced a special enrollment period (SEP) from March 15 to April 30, 2015, for individuals and families who are subject to shared responsibility payments on their 2014 tax returns because they did not have health coverage have an opportunity to obtain coverage for 2015. To be eligible for the SEP, consumers must live in states with the federally facilitated Marketplace, HealthCare.gov, and attest that they either were not aware of or did not understand the tax implications of not having minimum essential coverage as required by the ACA.

CMS Administrator Marilyn Tavenner explained the SEP, saying "We recognize that this is the first tax filing season where consumers may have to pay a fee or claim an exemption for not having health insurance coverage. Our priority is to make sure consumers understand the new requirement to enroll in health coverage and to provide those who were not aware or did not understand the requirement with an opportunity to enroll in affordable coverage this year."

5. Medicaid DSH Payment Reductions

Section 2551 of the ACA adjusts the Medicaid disproportionate share hospital (DSH) payment increase. A DSH is a hospital that (1) serves a significantly disproportionate number of low-income patients; or (2) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding Medicare and Medicaid payments) for indigent care from state and local government sources exceed 30 percent of its total inpatient care revenues.

As written, the ACA calls for DSH allotments to states to be reduced for each fiscal year (FY) 2014 through 2020 and payments to states would be reduced for each quarter in the FY in an amount equal to 1/4 of the DSH allotment reduction. The aggregate reductions for each FY were scheduled as follows:

- $500 million for FY 2014;
- $600 million for FY 2015;
- $600 million for FY 2016;
- $1.8 billion for FY 2017;
- $5 billion for FY 2018;
- $5.6 billion for FY 2019; and
- $4 billion for FY 2020.

Delays, expansions, and increases. The Medicaid DSH reduction has been delayed twice. The Pathway for SGR Reform Act of 2013 (*P.L. 113-67*) delayed the reductions until FY 2016 through FY 2022. It also doubled the reduction that would have applied in FY 2016 to $1.2 billion. It added a year on to the schedule, FY 2023, and created a special rule for calculating DSH allotments that year, making the FY 2023 DSH allotment equal to the DSH allotment for FY 2022, increased by the percentage change in the consumer price index for all urban consumers in FY 2022. The Protecting Access to Medicare Act of 2014 (*P.L. 113-93*) again delayed the Medicaid DSH reductions, which are now due to begin in FY 2017 and continue through FY 2024.

Katherine Neuhausen, MD, MPH, the Associate Director, Office of Health Innovation, and an assistant professor in the Department of Family Medicine and Population Health, at Virginia Commonwealth University, explained that when Congress delayed the start of the reductions, "the delay came at the cost of increasing the size and duration of the reductions. While the Medicaid DSH reductions included in the ACA were a total of $18

billion and ended in 2020, Congress increased the total size of the reductions to $35 billion and extended them until 2024." Neuhausen added, "By kicking the can down the road, it has become much harder for Congress to find the cost offsets to eliminate the DSH reductions and restore full DSH funding to safety-net hospitals."

Looming catastrophe. Neuhausen described the Medicaid DSH payment reductions as "a looming catastrophe for safety-net hospitals," particularly those in states that have opted out of Medicaid expansion based on the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* (*NFIB*), which held that Medicaid expansion under the ACA was optional for states rather than mandatory. She said that *NFIB* "altered the fiscal math justifying the DSH cuts and created severe financial challenges for safety-net hospitals in states that are not expanding Medicaid. The ACA assumed that the Medicaid DSH reductions would be balanced by new revenue for safety-net hospitals and a decrease in uncompensated care costs after Medicaid expansion. The fiscal math doesn't work in states that refuse to expand Medicaid because their safety-net hospitals do not have the new Medicaid revenue to offset the deep DSH cuts."

Dylan H. Roby, Ph.D., an assistant professor in the Department of Health Policy and Management and a Senior Research Scientist at the Center for Health Policy Research, both in the Fielding School of Public Health at the University of California, Los Angeles, agreed with Neuhausen's assessment. Roby stated that because the Medicaid DSH payment cuts "are partially based on state policy and partially based on the continued burden of uninsured caseloads and Medicaid shortfalls (i.e. underpayment) in each state. . . . it is more difficult to predict what the exact reduction will be for a specific hospital, because it will be a function of the Medicaid and low-income uninsured who end up seeking care at that hospital in a given year, as well as the payment shortfalls that Medicaid patients might result in (if a state does not pay hospitals at cost or better for Medicaid services)."

Preparation. Neuhausen recommended that hospital leaders "focus on becoming more efficient and delivering more cost-effective and high value health care," because "by decreasing their overall costs, including their costs for uncompensated care, they can decrease some of their need for DSH payments." However, she warned that despite options for safety-net hospital leaders to "work with state policymakers to ensure that Medicaid DSH payments in their states are targeted to the safety-net hospitals that serve the most uninsured and Medicaid patients," and to "seek out additional county and state subsidies," a safety-net hospital in states that decline to expand Medicaid is unlikely to be saved even if all attempts to obtain additional funding are successful. Neuhausen noted that "States that continue to reject Medicaid expansion risk harming the financial viability of their safety-net hospitals, leading to cuts in the many vital community services such as trauma care these hospitals provide to their communities, and threatening hospital closures. If state leaders continue to let politics trump economics and health, safety-net hospitals and the millions of poor Americans they care for will suffer."

> *"The objective to get most if not all people covered … and finance this cost over time with savings and penalties for noncompliance is lofty—but remains possible."*
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> — Donna Fraiche
> Baker, Donelson, Bearman, Caldwell & Berkowitz
> Chair of the Louisiana Health Care Commission

Roby added a recommendation that hospitals "keep an eye on state policy decisions through their hospital association, which will have a government relations office that knows the DSH payment formulas well." He also warned, "While the ACA tries to link the reduction in DSH revenue to a reduction in the number of uninsured patients, there is no guarantee that any one hospital will continue to see those patients when they become insured. In some safety-net facilities, they should be concerned that once someone becomes insured via Medicaid or private insurance through their employer, the individual market, or the state/federal Marketplace, that patient won't necessarily come back to those safety-net providers due to perceptions about quality or reputation, waiting times, convenience, insurance networks, and other factors."

Conclusion

Five years into the ACA, the law has had a big impact on health coverage in the United States; however, there

are a number of large changes that have not yet been implemented, while other changes have begun but the full effects have not been seen. When asked if continued improvement under the ACA is sustainable, Fontenot answered, "Absolutely. On every front. . . . On the Medicaid front, the value of expansion in coverage to a state and its citizens make me fundamentally optimistic that over time coverage will continue to improve. It will just take longer. And it will take several more years before we see the full effect of the delivery system reforms, but changing large institutions isn't easy, and it takes time."

"The objective to get most if not all people covered in some form or bucket and finance this cost over time with savings and penalties for noncompliance is lofty—but remains possible," Fraiche said. "Perhaps a prediction of $143 billion in savings over time was overreaching but is still in the realm of possibility if all participants could work together to achieve getting a healthier population with less variation in cost and care and better outcomes."

Although pending litigation and political reactions continue to cloud the ACA's future, it is meeting some of its goals. The uninsured rate is down and consumer subsidies have increased coverage. Despite heavily publicized litigation, women are taking advantage of the ACA's contraceptive coverage provisions and consumers have seen changes in insurer behavior.

Not bad for a five-year-old.

As the ACA ages, however, the Medicaid DSH payment reduction has become a "looming catastrophe," with delays and choices made by states about whether to expand their Medicaid programs leading to disastrous consequences for some safety-net hospitals. The individual mandate penalties are coming as a surprise to some taxpayers, and the resulting SEP may not be enough to ensure that Americans obtain the required health insurance coverage. The HAC reduction program contains mandatory penalties for 25 percent of hospitals, and will likely need to be revisited as hospitals continue to become safer. Lastly, the employer mandate and recordkeeping requirements officially began on January 1, 2015, but how well employers comply and the ensuing consequences will not be known until 2016. The long-term success of the ACA depends heavily on many of these provisions, and Wolters Kluwer will continue to monitor all developments.