Implementing Health Reform: Four Years Later

Despite enormous potential, the Affordable Care Act has been plagued by controversy and confusion from day one.

BY TIMOTHY S. JOST

January 1, 2014, was to be a day of triumph for Affordable Care Act (ACA) supporters. All Americans, regardless of income or preexisting medical conditions, would have access to health insurance. Medicaid would cover all low-income Americans under age sixty-five. Premium tax credits would make health insurance affordable for families with incomes up to four times the poverty level—well above the median income level. Although Americans with employer-sponsored insurance would see their coverage continue largely unchanged, benefits in the individual and small-group market would become more comprehensive, and out-of-pocket costs would be capped. Medicare benefits would continue to improve as the Part D prescription drug “doughnut hole” closed. Millions of Americans long denied access to health care would have insurance, just like the rest of us.

To read the headlines as 2014 arrives, however, it doesn’t appear to have turned out that way. The news is dominated by reports that Americans in the individual insurance market have received “cancellation” notices telling them that their 2013 policies are no longer available. Millions of Americans with incomes below 100 percent of poverty will be too poor to qualify for coverage in states that are refusing to expand Medicaid. Employers are reportedly cutting back the hours of part-time employees to avoid providing them health coverage.

Worst of all, the health insurance Marketplaces, which were supposed to enroll seven million Americans in coverage for 2014, largely failed for their first two months, and most are still not fully functional, blocking potential enrollees from getting coverage.

How did things go so wrong? Why is there so much bad news? When can we expect the news to get better?

In The Beginning

It was clear from the beginning that implementation would not be easy. Instead of creating an entirely new health care financing system, as Medicare and Medicaid had done in the 1960s, the ACA attempted to build on the current system. Medicaid would be expanded; employer coverage would be preserved; Medicare would be left largely untouched; and states would be left in control of their insurance markets. Only the individual and small-group markets would be substantially changed and only for the better.

But although building on the existing system was intended to minimize disruption, it in fact made implementation far more difficult and complex. The ACA is, for example, heavily dependent on state buy-in, as it retains traditional state administration of the Medicaid program and management of insurance markets. States were asked to expand their Medicaid programs dramatically, establish insurance exchanges, and sub-
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substantially change their insurance regulations.

But the ACA also depended on cooperation from small employers, which would need to purchase coverage that would be more comprehensive than existing plans. Some large employers would have to expand their benefits to cover dependents and some of their employees previously excluded as part-time employees. Insurers would need to change entirely their approach to underwriting.

Implementation also depended on cooperation among three federal departments—Health and Human Services, Labor, and Treasury—with different cultures and missions. Coordination—indeed, even communication—was not always easy. The White House also played a major role, given the political nature of most decisions. This, however, slowed and complicated implementation.

Finally, the legislation that emerged from Congress was flawed and adopted in the face of Republican opposition. Although the ACA had built on principles found in earlier Republican reform proposals, and the drafters accepted many Republican amendments, by late summer 2009 hopes of bipartisanship evaporated, leaving the Democrats to enact the legislation over determined Republican opposition. The loss of a Democratic supermajority in the Senate because of a Massachusetts special election (ironically, to complete the term of the late Sen. Ted Kennedy [D-MA]) left the Democrats with no alternative but to adopt a Senate bill that was never intended to be the final legislation. Issues that could have been worked out in conference committee have posed ongoing challenges.

Implementation got under way swiftly. By early summer 2010, regulations had been issued implementing the transitional preexisting condition insurance and early retirement reinsurance programs as well as the small-employer tax credit. Regulations followed on schedule throughout summer 2010, implementing the six-month reforms, prohibiting rescissions and lifetime limits, capping annual dollar limits, requiring internal and external appeals, extending parental coverage to adult children up to age twenty-six, and prohibiting preexisting condition exclusions for children.

Most of the 2010 reforms were implemented without major problems—but not all. The ban on preexisting condition exclusions for children, interpreted broadly by the administration to eliminate all health status underwriting for children, caused the market for child-only insurance to collapse in many states. Pushback from employers forced the administration to grant temporary “mini-med” waivers excluding four million enrollees from the protection of the dollar-limit requirement.

Opposition Grows

Initial signs of cooperation with the states also seemed promising. All but one of the states accepted initial exchange planning grants, although several returned them later. Forty-six states began updating their Medicaid enrollment systems, with 90 percent federal funding. But from the beginning, implementation faced vigorous opposition. As the ink from the president’s signature dried, lawsuits were filed challenging the constitutionality of the law. Lawsuits brought by both Florida and Virginia succeeded in the district courts, and the Florida case prevailed in the federal Court of Appeals. Although other courts ruled in favor of the constitutionality of the ACA, the challenges headed for the Supreme Court.

More devastating for the future of the ACA, however, were the 2010 midterm elections. Republicans picked up sixty-three seats in the House, swinging control of the chamber from the Democrats to the Republicans. Before the 2010 elections, Democrats controlled fifty-two state legislative houses and the Republicans thirty-three; after the elections, Republicans controlled fifty-three and the Democrats thirty-two. Before the 2010 elections there were twenty-six Democratic and twenty-four Republican governors, and after there were twenty Democrat and twenty-nine Republican. Many saw the election as a referendum on the ACA.

ACA implementation continued during 2011 and 2012, as provisions went into effect requiring insurers to pay rebates to their enrollees when they failed to spend at least 80 percent of their premiums on claims (85 percent for large groups) and to justify “unreasonable” premium increases. A new requirement that insurers and health plans provide enrollees with a uniform summary of benefits and coverage was also implemented. And the regulatory groundwork was laid for the 2014 reforms.

As implementation proceeded, the administration became increasingly sensitive to the demands of insurers and employers, watering down the summary of benefits and coverage and appeals requirements and delaying the imposition of other employer obligations.

Opposition to reform, however, continued to build. Republican dominance of the House made technical corrections to the ACA impossible, forcing implementation workarounds. Initial expectations that most states would create their own exchanges were dashed following the 2010 elections. As it became clear that the federal government would have to run the exchanges in most states, the Department of Health and Human Services continued to look for ways to keep the states in the game, first creating partnership exchanges and then allowing states to control their insurance markets without even declaring partnership status.

In 2012 the ACA survived two fundamental challenges. The first was the Supreme Court’s five-to-four decision upholding the individual mandate as a tax. The second was President Barack Obama’s electoral defeat of Gov. Mitt Romney, who had promised to block the implementation of the law. The ACA did not survive unscathed, however. The Supreme Court decision badly undermined the ACA’s coverage expansions by allowing states to opt out of the Medicaid expansion. Almost half of the states have done so, leaving 11.5 million Americans uninsured. Moreover, the administration also put a hold on new implementation regulations in the run-up to the 2012 election—apparently for political reasons—slowing implementation.

A flood of new regulations and guidance emerged following the 2012 election and continued into 2013. The pace of building the technological infrastructure for the exchanges quickened as well, as it finally became clear that the federal exchange would have to serve
two-thirds of the states. Parts of the program fell badly behind schedule, however, including construction of the exchange website and creation of the Navigator program, which was supposed to help educate and enroll individuals in the exchange. Implementation of the employer mandate also faltered, leading to a one-year implementation delay.

Vehement Republican opposition to the ACA continued—and arguably even increased—with the House holding more than forty votes to repeal the legislation. Ultimately, the House shut down the federal government for sixteen days, insisting that government funding be conditioned on ACA defunding. House committees also held interminable and repetitive oversight hearings, which have distracted key administration personnel from their increasingly urgent tasks. The House blocked all appropriations for implementation, forcing the agencies to cannibalize resources from other programs and operate on limited funding.

The greatest blow to the ACA came not from its enemies but from those charged with implementation, as the online federal Marketplace opened on October 1, 2013, and immediately crashed. Apparently, multiple technical and political failures drove the design of a defective, nonfunctional Healthcare.gov website—a tremendous embarrassment to the ACA and its supporters.

On top of this, millions of individuals insured in the nongroup market received notices that their 2013 coverage was no longer available. The individual market has always been very volatile, with coverage rarely lasting more than a couple of years. But because policies that do not conform to the 2014 underwriting and coverage requirements are no longer legal after 2013, millions of policy nonrenewals seemed to happen all at once.

It also appears that some plans grandfathered under the original 2010 legislation have been cancelled by insurance companies, even though they remained legal. An “administrative fix” hastily put together by the administration allows some people to renew their 2013 policies in 2014. Many more will find that individual coverage available through the exchange with premium tax credits will cost them less than before, but some will find themselves paying more for coverage that might not be as good as what they had before.

Looking Ahead
It is likely that more complaints will be heard once people actually use their ACA coverage. Many exchange carriers are offering limited provider networks. Narrow networks allow insurers to reduce premiums as they exclude the most expensive providers and negotiate steep discounts with those who remain. Consumers will like the low premiums but will be unhappy to learn that their doctors are not available and shocked to discover charges from out-of-network specialists when they go to in-network hospitals.

Consumers may also be surprised by the magnitude of cost sharing under ACA plans. Bronze plans may have $6,000 deductibles, and silver plans can have deductibles of $2,000 or more. Even at these levels, of course, cost-sharing obligations will be lower than many policies found now in today’s nongroup market. Moreover, individuals with incomes below 200 percent of poverty will qualify for cost-sharing reduction payments that will greatly reduce cost sharing if they buy a silver plan. And out-of-pocket limits will be capped—at $6,350 for individuals and $12,700 for families initially. But this is not free care, or anything close to it.

Millions of low-income Americans in states that refuse to expand Medicaid will find themselves too poor to receive any help. This is, of course, not the fault of the ACA but rather of its opponents. But the public may not grasp this distinction.

Other problems will also attend the implementation of the 2014 reforms, and all will be widely reported. Employers may continue to reduce employees to thirty hours or otherwise try to avoid offering health insurance to their employees. Insured and self-insured plans will bear part of the cost of expanding coverage and reinsuring high-cost enrollees in the individual market, increasing their costs. Fraud and identity theft schemes are already preying on people’s confusion and fears about the ACA. Finally, public outrage is sure to hit the headlines again when tax filing time arrives in 2015 as some individuals will be assessed the penalty for remaining uninsured, while others will face a repayment demand for overpaid premium tax credits.

Bad news sells better than good news. There is, moreover, a determined campaign to make certain that bad news concerning the ACA remains constantly in the public eye. It is likely that negative stories about the ACA will dominate the news for some time.

But as the Healthcare.gov website becomes fully functional, good news will also begin to seep through. Millions of Americans who are now without any health coverage are being signed up for Medicaid. Millions more will receive premium tax credits that will make coverage affordable. Indeed, many will receive zero-premium coverage, although it will be bronze coverage with high cost sharing. In any event, the out-of-pocket limits will shield most covered families from financial disaster.

Coverage in the individual and small-group market will be more comprehensive, including broader coverage for mental health and substance use disorders, habilitation, and pediatric oral and vision services. Although some employers may drop coverage because their employees can get better coverage through the exchanges, others may add coverage under pressure from the employer mandate and from their employees, who will demand coverage to avoid the individual mandate penalty. The Medicare Part D prescription drug benefit doughnut hole will continue to close. And the recent slowdown in the growth of health care costs to historically low rates will limit federal and private payers’ expenditures under the law.
Winners, Losers, And Signs Of A Brighter Future

It was clear from the beginning that there would be winners and losers under the ACA and that some of the winners might perceive themselves as losers. This was less true with earlier health reforms of the US health care system. Medicare beneficiaries are uniformly better off than they would be without coverage. Indeed, until now, most ACA reforms have brought real benefits with few visible costs. But it is impossible to move from a system in which people with preexisting conditions can be denied health coverage or charged much higher premiums to a system where people pay the same premium regardless of their health without some who have previously benefited having to pay more.

Going forward, one of the most important challenges facing the ACA will be whether its benefits become apparent quickly and dramatically enough to offset the problems that are currently dominating the news coverage of the health reform law. Even more important may be the question of how much it will matter that the greatest beneficiaries of the ACA are likely to be low-income Americans, who are less likely to be politically active than many of the higher-income Americans who will be adversely affected by higher insurance premiums and taxes.

In the end, the most important fact is that the ACA addresses a real and dramatic problem: nearly fifty million uninsured Americans.

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