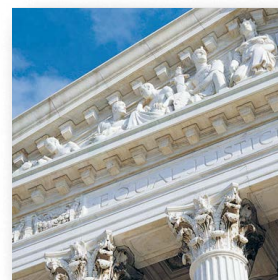


From Then Until Now: A Top-Down View Of The Affordable Care Act

Patrick R. LaFontaine, PharmD; F. Randy Vogenberg, PhD, RPh; and Laura T. Pizzi, PharmD, MPH



INTRODUCTION

It has been nine years since the Patient Protection and Affordable Care Act (ACA), often informally referred to as Obamacare, was signed into law. The act brought about the most significant



F. Randy Vogenberg

Secretary of the Department of Health and Human Services (HHS) to “waive, defer, grant exemption from, or delay the implementation of any provision or requirement of the ACA that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers

expansion of and change to U.S. health insurance coverage since the formation of Medicare in 1965. On January 20, 2017, President Donald Trump issued an executive order authorizing the

of medical devices, products or medications.”¹ The main components of ACA were the expansion of Medicaid, changes in private (commercial) insurance coverage, the establishment of health exchanges, employer requirements for providing healthcare coverage, and the introduction of the individual mandate.

It is important for healthcare professionals and pharmacy and therapeutics (P&T) or related committees in all practice settings to realize that today’s ACA differs from the original 2010 act. As plan requirements, government funding, and patient affordability change, so too must the plans offered by third-party healthcare payers or purchasers (employers, municipalities, and unions). To provide patient-centered care in today’s healthcare environment, understanding the system within which patients and providers function is more important than ever. Thus, we present a top-down view of ACA 2010 (“then”) versus ACA today (“now”).

COMPARISON OF CHANGES TO THE AFFORDABLE CARE ACT

1. Expansion of Medicaid

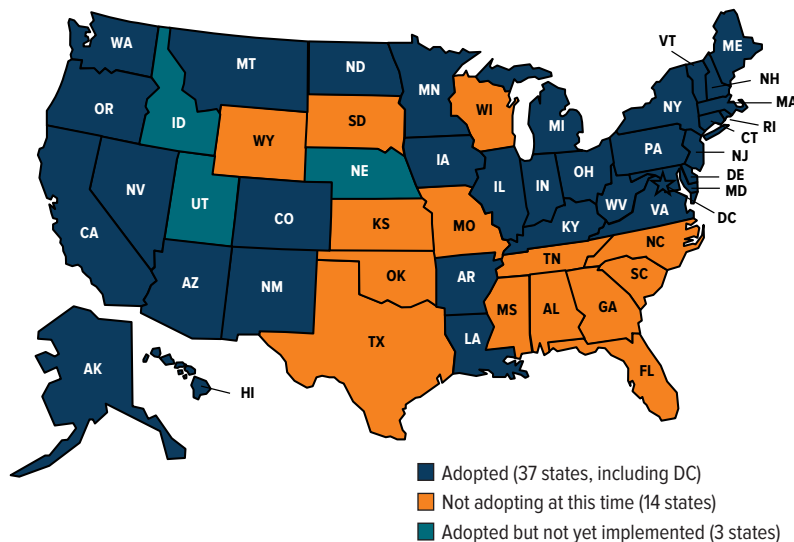
Then:²⁻⁴ Medicaid’s expansion increased the availability of services to people with incomes of up to 138% of the federal poverty level, based on modified adjusted gross income. The change is estimated to have provided an additional 11 million Americans with health insurance coverage.

Now:⁴ Almost immediately after ACA was passed, states began suing the federal government, claiming that it could not mandate the expansion of Medicaid programs. The Supreme Court overturned this portion of the act in 2011, and program expansion became optional. At present, only 14 states have not adopted the expanded programs (Figure 1).⁵ Initially, many states that did adopt the expansion experienced a decrease in state Medicaid spending because of increased spending at the federal level.

Dr. LaFontaine is a Post-Doctoral Fellow and Adjunct Faculty Member at Rutgers University’s Ernest Mario School of Pharmacy, in Piscataway, New Jersey. He is pursuing a Master’s degree in Health Outcomes, Policy, and Economics under the guidance of Dr. Pizzi; Dr. Vogenberg is Principal, Institute for Integrated Healthcare, Greenville, South Carolina, and Adjunct Professor, Department of Pharmacy Practice, HOPE Center, Ernest Mario School of Pharmacy, Rutgers University, in Piscataway; and Dr. Pizzi is Director of the Center for Health Outcomes, Policy, and Economics (HOPE) and HOPE Master’s Program; Professor, Department of Pharmacy Practice in the Ernest Mario School of Pharmacy; and Professor, Department of Health Systems and Policy, Rutgers School of Public Health at Rutgers University in Piscataway.

Disclosure: The authors declare no financial or commercial interest in regard to this article.

Figure 1 Status of State Action on the Medicaid Expansion Decision⁵



NOTES: Each state’s current status is based on Kaiser Family Foundation (KFF) tracking and analysis of state activity.

Source: “Status of State Action on the Medicaid Expansion Decision,” KFF State Health Facts, updated May 13, 2019.

In 2018, however, the federal match rate began to decrease, and the states that adopted the expansion will be responsible for 10% of total Medicaid spending by 2020. These changes have resulted in a state Medicaid spending growth of 4.9%, which is larger than the federal growth of 4.2%. Some states have had to come up with additional sources of financing to pay for these increases.⁶ In February of this year, Senators Mark Warner (D-VA), Tim Kaine (D-VA), Doug Jones (D-AL), and others introduced the States Achieve Medicaid Expansion (SAME) Act of 2019. This legislation would supplement federal Medicaid spending for states that chose to expand Medicaid after 2014, and allow states that haven't expanded Medicaid to do so.⁷

2. Changes to Private Insurance Coverage

Then:^{2,3} In addition to expanding public programs, the ACA established new coverage guidelines on plan eligibility and scope that private insurers must follow. The most well-known policy deriving from the changes prevents insurers from denying coverage to individuals based on pre-existing medical conditions. Another part of the rule made it illegal for insurers to charge a greater fee based on a person's health status or gender. And coverage was also expanded for young adults, who can claim dependent status on their parents' health insurance up to the age of 26, with no restrictions regarding their living situation, financial independence, or health insurance options offered by their employer. Insurers were also prohibited from imposing lifetime limits on coverage, and this coverage could not be rescinded. Furthermore, to encourage wellness checks, the act established mandatory minimum coverage standards known as "essential health benefits" (Figure 2)⁸ and instituted zero-dollar co-payments for many preventive health services.

Now: A number of these changes are still in place within the healthcare system. The major point of contention has centered on the list of essential health benefits. Many states have argued that the list infringes on people's right to purchase a plan that is specific to their needs. But religious objections to the mandatory contraception coverage, for example, have led to some adjustments.

Figure 2 Essential Health Benefits Established by the Affordable Care Act⁸



Credit: Patrick LaFontaine

On November 7, 2018, HHS released two final rules on religious and moral objections to the mandatory coverage: Certain exempt religious employers who sponsor health plans for their employees do not have to cover contraceptive methods and counseling. Further, non-profit religious organizations do not have to contract, arrange, pay, or refer someone for contraceptive coverage if they have religious objections to contraceptive coverage.^{9,10}

In the HHS Notice of Benefit and Payment Parameters for 2019, issued on April 17, 2018, the essential health benefits benchmarks will be adjusted beginning in 2020. The ruling enables

states to adopt the benchmarks used by another state, or to create their own set of essential health benefits that would be used for future benchmarking practices. This allows states a much greater flexibility for changing the scope of the essential health benefits they offer on the exchanges.¹¹

In an executive order issued on October 12, 2017, President Trump expanded access to association health plans (AHPs) for small employers, and short-term, limited-duration insurance (STLDI) plans for individuals. Both plans are exempt from the mandated coverage minimums under the ACA and can be used as a workaround to offer less expensive plans to employees and individuals.¹² On March 29, 2019, a federal judge blocked key provisions of the AHP Final Rule. The judge determined that the Final Rule unlawfully expands AHPs to allow small businesses and individuals to avoid the healthcare market requirements imposed by ACA, and that the definition of an AHP undermines the market structure the act put in place. The decision is expected to be appealed.¹³

3. The American Health Benefit Exchanges

Then:^{2,3} The establishment of the American Health Benefit Exchanges, also known as "the exchange" or "the health insurance marketplace," presented Americans with a new option for health insurance. The exchanges provide a centralized place for individuals and small employers to compare and purchase private insurance plans, which were categorized from bronze (low premium, high deductible) to platinum (high premium, low deductible), based on actuarial value. The original legislation stipulated an open enrollment period of 90 days, during which individuals could sign up for insurance on the health insurance marketplace with the help of a federally funded "health insurance navigator" program. To provide affordability assistance, two fundamental types of subsidies were established. First, premium tax credits were offered to individuals whose income was between 100% and 400% of the federal poverty level. Eligibility for tax credits was based on the difference between the benchmark premium (second-lowest silver-tier plan premium) and an income-based premium cap. Second, cost-sharing subsidies were

also available for people with incomes between 100% and 250% of the federal poverty level. These subsidies limited out-of-pocket maximums for patients enrolled in silver tier plans, and increased the plans' actuarial value to that of the gold and platinum plans, depending on one's income level.

Now: Although the marketplace structure hasn't fundamentally changed, the way in which the program is administered and financed has been altered. Beginning in 2017, the open enrollment period for 2018 was reduced to 45 days.¹⁴ For 2019, nine states and the District of Columbia opted to extend the deadline.¹⁵ Also, navigator program funding has decreased by 84% and marketplace advertising has been cut by 90%.¹⁴ The cuts have had some effect: according to a Kaiser Family Foundation poll from November 2018, only 24% of Americans knew the correct 2019 open enrollment deadline was for 2019.¹⁶ After the 2017 election, the Trump Administration announced an end to cost-sharing subsidy payments to insurers from October of that year. Currently, insurers are required to pay subsidies to patients without receiving reimbursement from the government. This has, predictably, led to an increase in silver-tier plan premiums—known as “silver loading”—to compensate for the eliminated reimbursements. Because of variations between states, some insurers opted to recoup what they pay as silver-tier subsidies by marginally increasing their premiums across all health plans, although the practice isn't common.¹⁷ For 2019, 4.2 million Americans (27% of the uninsured population) were estimated to be eligible for a zero-dollar premium, bronze-tier plan after the application of subsidies.¹⁸

4. Employer Requirements for Providing Health Coverage

Then and Now: In its original form, ACA set out guidelines for employers with more than 50 full-time employees and instituted financial penalties for those who were unwilling to comply. Although the penalty amounts have changed since 2010, the system structure remains the same. Following are the 2019 penalties for employers who do not offer coverage under ACA, and some options for small employers (less than 50 employees) to provide coverage.

Requirements

- Any employer who had fewer than 50 full-time or equivalent employees in the previous year will not be penalized for failing to offer health insurance coverage.¹⁹
- If an employer does not offer insurance coverage to at least 95% of its full-time workers and their dependent children, and at least one employee received a premium tax credit or cost-sharing subsidy, the employer must pay a monthly penalty of \$193.33 times the number of full-time employees (minus up to 30 employees).¹⁹
- If an employer offers insurance coverage to at least 95% of its full-time workers and their dependent children but the plans do not pay at least 60% of the covered healthcare expenses for a standard population (“minimum value” criteria), and at least one full-time employee receives a premium tax credit, the employer must pay a monthly penalty of \$290 per employee receiving a premium tax credit up to a maximum penalty equivalent of the employer providing no coverage, as described previously.¹⁹
- If an employer offers insurance coverage to at least 95% of its full-time workers and their dependent children, and the insurance plan meets the “minimum value” but any employee has to pay more than 9.86% of their household income for employer coverage (“affordable coverage” criteria), and at least one full-time employee receives a premium tax credit, the employer must pay the monthly penalty equivalent to the penalty for not meeting the “minimum value” criteria.^{19,20}
- In order to incur no financial penalty, the employer must offer insurance coverage to at least 95% of its full-time workers and their dependent children, and the insurance plan must meet both the “minimum value” and “affordable coverage” criteria, as described above.¹⁹

Options for Small Employers

There are multiple options for small business employers to provide health insurance to their employees if they do not meet the 50-employee threshold for

employer requirements. In 2015, the small business health options program (SHOP) was started, which functions as a health insurance marketplace for small business owners. Enrolling in a SHOP plan is a way for small businesses to claim a Small Business Health Care Tax Credit.²¹

In addition to SHOP, a qualified small employer health reimbursement arrangement (QSEHRA) is a method that small employers can pursue to help employees pay for medical expenses, including premiums for individual health plans.²¹

Tax-favorable plans such as Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs) are designed to enable individuals, and their employers, to make pre-tax contributions to employee health funds. These funds offer individuals greater flexibility with their healthcare-designated dollars.²¹

As we discussed earlier, association health plans (AHPs) allow small employers, and certain self-employed workers, to join together based on location or industry to obtain health coverage as a large employer would, although the legality of this program is under debate.^{13,21}

5. The Individual Mandate

Then:² A highly controversial aspect of ACA was the individual mandate. In 2010, the act laid the groundwork for supplementing insurance-risk pools with healthier patients by instituting an individual mandate for health insurance. Beginning in 2014 and extending through 2016, patients without insurance coverage were required to pay an annual tax penalty.

Now: On December 20, 2017, the Tax Cuts and Jobs Act passed by Congress finalized the individual mandate's permanent repeal, with the penalty phasing out in 2019.²¹ As conversations about the repeal were heating up in 2017, the Congressional Budget Office (CBO) estimated what repealing the mandate would cost: the report concluded that the number of people with health insurance would decrease by four million in 2019, and increase to 13 million by 2027.²² The CBO also estimated that non-group marketplace insurance premiums would increase by around 10% year over year, during the next decade.²³ Notably, these

estimates assumed that cost-sharing reduction subsidies (which lower the amount that qualified individuals pay for deductibles, copayments, and coinsurance) would be funded, but those have also been cut.

CONCLUSION

Understanding the health plan programs that are allowed or are already in place is vital for practicing professionals and P&T or related committees in all healthcare settings today. Decision-makers are affected to some degree by the current landscape, so it is essential to comprehend the market-based risk trends associated with purchasing or providing health care. Compliance or risk avoidance, even with the status quo, is increasingly important, and the patient-focused changes resulting from the consumer-driven political landscape continue to evolve.

In the public insurance sector, expanding Medicaid has given coverage to a subset of Americans who were unlikely to be able to afford insurance before the ACA was passed. But as state budgets begin to shoulder more of the cost of these programs, Medicaid plan sponsors will likely face additional pressure to limit costs.

For private insurance providers, ACA changes have generated increased coverage options for their beneficiaries. Pharmacy and therapeutics committees have greater flexibility concerning therapy access or restrictions; this has improved the balance between clinical and economic factors, especially regarding essential health benefits. As state benchmarking for these benefits increases, greater flexibility is expected. In addition, the insurance exchanges continue to provide a value-based perspective to consumers, and a centralized access point for comparing insurance plans. As more information becomes available to consumers, tailored health plans across all tiers will continue to grow in importance.

Since ACA's passage in 2010, various changes have occurred that affect how the legislation functions. The "repeal and replace" approach and/or the "Medicare for All" or single-payer schemes could be the paradigm facing us in the near future. Whichever approach is finally decided upon, expanding access to coverage and containing costs while maintaining quality

will remain paramount concerns as legislators continue the struggle to achieve greater value in health care.

REFERENCES

1. Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS notice of benefit and payment parameters for 2019. *Fed Regist* 2018;83(74):16930–17071. Available at: <https://www.federalregister.gov/d/2018-07355>. Accessed June 26, 2019.
2. Kaiser Family Foundation. Summary of coverage provisions in the Patient Protection and Affordable Care Act. July 17, 2012. Available at: <https://www.kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient/>. Accessed June 26, 2019.
3. Department of Health and Human Services. About the Affordable Care Act. December 7, 2017. Available at: <https://www.hhs.gov/healthcare/about-the-aca/index.html>. Accessed June 26, 2019.
4. UCSF/UC Hastings Consortium on Law, Science and Health Policy. Health Reform Tracker. 2017. Available at: <http://www.healthreformtracker.org/medicaid-changes-under-the-affordable-care-act/#Introduction>. Accessed July 8, 2019.
5. Kaiser Family Foundation. Status of state Medicaid expansion decisions: interactive map. May 13, 2019. Available at: <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>. Accessed June 26, 2019.
6. Rudowitz R, Hinton E, Antonisse L. Medicaid enrollment & spending growth: FY 2018 & 2019. Kaiser Family Foundation. October 25, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/>. Accessed June 26, 2019.
7. Senator Doug Jones introduces bill to incentivize Alabama, 13 other states to expand Medicaid. Doug Jones. February 27, 2019. Available at: <https://www.jones.senate.gov/newsroom/press-releases/senator-doug-jones-introduces-bill-to-incentivize-alabama-13-other-states-to-expand-medicaid>. Accessed June 26, 2019.
8. National Conference of State Legislatures. State insurance mandates and the ACA essential benefits provisions. April 12, 2018. Available at: <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>. Accessed June 26, 2019.
9. Keith K. Religious, moral exemptions from contraceptive coverage mandates: second verse, same as the first. *Health Affairs* blog. November 9, 2018. Available at: <https://www.healthaffairs.org/do/10.1377/hblog20181109.87594/full/>. Accessed June 26, 2019.
10. Centers for Medicare & Medicaid Services. Birth control benefits. Available at: <https://www.healthcare.gov/coverage/birth-control-benefits/>. Accessed June 26, 2019.
11. Centers for Medicare & Medicaid Services. Information on essential health benefits (EHB) benchmark plans. Available at: <https://www.cms.gov/ccio/resources/data-resources/ehb.html>. Accessed June 26, 2019.
12. The White House. Presidential executive order promoting healthcare choice and competition across the United States. October 12, 2017. Available at: https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/?utm_source=link. Accessed June 26, 2019.
13. Porter, S. Judge blocks association health plans rule as unlawful effort to bypass ACA. *HealthLeaders*. March 29, 2019. Available at: <https://www.healthleadersmedia.com/strategy/judge-blocks-association-health-plans-rule-unlawful-effort-bypass-aca>. Accessed June 26, 2019.
14. Obamacare: has Trump managed to kill off Affordable Care Act? BBC News. March 29, 2019. Available at: <https://www.bbc.com/news/world-us-canada-24370967>. Accessed June 26, 2019.
15. Folger J. Alert: shorter enrollment for Affordable Care Act again this year. Investopedia. December 14, 2018. Available at: <https://www.investopedia.com/insurance/open-enrollment-affordable-care-act-shorter-this-year/>. Accessed June 26, 2019.
16. Kirzinger A, Wu B, Brodie M. KFF health tracking poll–November 2018: priorities for new congress and the future of the ACA and Medicaid expansion. Kaiser Family Foundation. November 28, 2018. Available at: <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priorities-congress-future-aca-medicaid-expansion/>. Accessed June 26, 2019.
17. Norris L. The ACA's cost-sharing subsidies. *Healthinsurance.org*. June 21, 2019. Available at: <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/#funding>. Accessed June 26, 2019.
18. Fehr R, Claxton G, Cox C, Levitt L. How many of the uninsured can purchase a marketplace plan for free? Kaiser Family Foundation. December 11, 2018. Available at: <https://www.kff.org/health-reform/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free/>. Accessed June 26, 2019.
19. Kaiser Family Foundation. Employer responsibility under the Affordable Care Act. March 5, 2018. Available at: <https://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>. Accessed June 26, 2019.
20. M3 Insurance. ACA update: employer shared responsibility affordability in 2019. May 31, 2018. Available at: <https://www.m3ins.com/blog/aca-update-employer-shared-responsibility-affordability-in-2019/>. Accessed June 26, 2019.

continued on page 493

continued from page 470

21. Centers for Medicare & Medicaid Services. Health insurance for small businesses. Available at: <https://www.healthcare.gov/small-businesses/learn-more/explore-coverage/>. Accessed June 26, 2019.
22. Tax reform bill includes repeal of individual mandate beginning in 2019. Cigna. December 20, 2017. Available at: <https://www.cigna.com/health-care-reform/news/tax-reform-bill-includes-repeal-of-individual-mandate-beginning-in-2019>.
23. The Bipartisan Health Care Stabilization Act of 2017 and the Individual Mandate. Congressional Budget Office. November 29, 2017. Available at: <https://www.cbo.gov/publication/53352>. Accessed July 3, 2019. ■