Bar Bulletin

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The Affordable Care Act

What's Next?

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The Supreme Court recently blessed the Affordable Care Act in a much awaited decision. It has been hailed by its proponents as the most progressive piece of social legislation since the creation of Medicare. Its' detractors portray it as a vast government overreaching. This article will lead us through the morass of the Affordable Care Act ("ACA") to help us understand what it was intended to do and how it is being implemented.

A LITTLE BACKGROUND

In public health circles, we like to remind everyone that medical care accounts for only about 10% of our overall health. Other determinants of our health include genetics, environment and lifestyle (e.g. diet, exercise, smoking). The ACA focuses primarily on the medical care side of health, with smaller investments in prevention and public health.

The Act also deals primarily with how we pay for medical care, rather than how we deliver medical care. The ACA does have pilot programs and innovations to test models of more efficient and effective delivery of care, but it primarily focuses on paying for coverage.

The Act only begins to address the spiraling costs of our medical care, which consumes $2.6 *trillion*, or 18% of our Gross Domestic Product. It is projected to bend the cost curve by increasing access to preventive and primary care, curbing some costly Medicare programs, incentivizing efficiencies such as electronic health records, and levying taxes on "Cadillac" health plans. But, there is much more to be done in that regard.

HOW THE ACA APPROACHES HEALTH COVERAGE REFORM

Congress had a choice of three basic approaches in health insurance reform.

The first option was to create a "single payer" system akin to extending Medicare to all United States residents. Under a single payer system the government would collect taxes and provide health insurance for all. Care would be provided primarily in the private sector, and providers would

be paid according to established fee schedules. Actuarial studies have shown that a single payer system in California would provide coverage for all Californians for approximately the same amount that we are spending now, primarily through reducing administrative costs and paying for insurance company's overhead and profit. A single payer system would make health insurance a "right, not a privilege."

The second choice Congress faced was to deregulate the health insurance industry. Although insurance is primarily regulated at the state level, Congress was urged by some to reduce insurance industry regulations, allowing plans to sell whatever products the market would support anywhere in the country. The underpinning to this approach is that health insurance is a commodity, much like any other commercial product.

The third and least risky alternative was to expand our present system of primarily employer-supplied private coverage for working families, public coverage for the elderly and low-income families, and a smaller individual market. Under our current system, some 50 million Americans (18.5% of nonelderly population) are without health coverage and the focus was to expand their access to coverage.

THE ACA'S MAIN COMPONENTS

1. Insurance reform

The ACA imposed a number of requirements on health plans designed to increase availability and quality of coverage. Plans are

required, among other things, to:

- Accept all applicants for coverage ("guaranteed issue"),
- Eliminate annual and lifetime coverage limits,
- Not charge deductibles for preventive care,
- Spend at least 80% of premiums on medical care ("medical loss ratio"),
- Cover children up to age 26 on their parents' policies; and
- Provide at least one plan with the ten "essential health benefits."

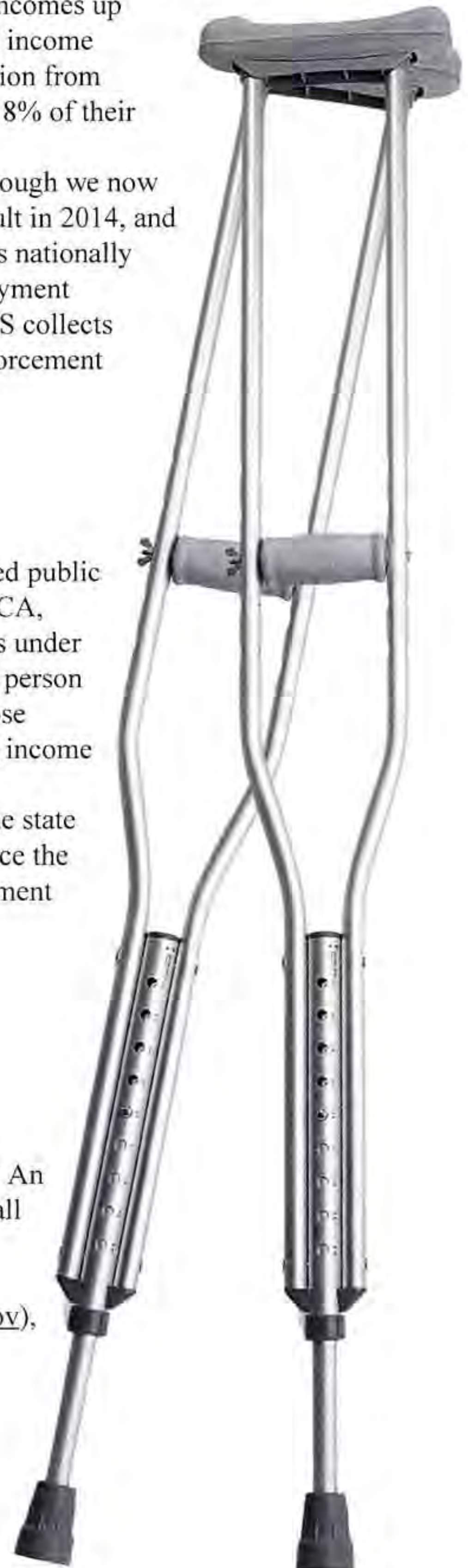
While the insurance reforms extended the opportunity of obtaining affordable coverage to millions of Americans, they also introduced the risk of "adverse selection." If everyone could now obtain coverage when they needed it, many would choose not to purchase it until that time. The result would be a risk pool of sicker individuals instead of a mix of healthy and unhealthy individuals. This is why Congress created the "individual mandate."

2. Individual mandate — play or pay "penalty"

Originally the idea of the conservative Heritage Foundation, and first implemented in Governor Mitt Romney's Massachusetts health reform legislation, the so-called individual mandate requires all citizens and legal residents to obtain "minimum essential" coverage or pay a penalty.

To ease the burden of health coverage, Congress developed a series of mechanisms to offset some of the costs. There are generous premium subsidies for those with incomes up to 400% of the federal poverty level (approximately $60,500 annual income for a two-person family), limitations on copayments, and an exemption from the mandate for those for whom the cost of insurance would exceed 8% of their income.

To enforce the individual mandate, the Act levies a penalty (although we now know for constitutional purposes it is a "tax") starting at $95 per adult in 2014, and rising to $695 per adult in 2016. Approximately one million persons nationally (2% of the currently uninsured) are expected to be subject to this payment which will be collected through tax returns. (Interestingly, while IRS collects the penalty, it cannot force anyone to pay through the usual IRS enforcement mechanisms such as wage attachment).



3. Expanded public coverage

In addition to making private insurance more available through underwriting reforms and premium subsidies, the ACA also expanded public coverage for the lowest income uninsured individuals. Under the ACA, Medicaid (Medi-Cal in California) would be expanded to all persons under 138% of the federal poverty level (approximately $20,900 for a two person family). Currently, Medicaid eligibility is generally restricted to those persons with minor children, the aged and the disabled with varying income thresholds by state and age.

Since Medicaid is a joint federal-state program (in California, the state and federal governments split the costs), Congress needed to convince the States to accept this expansion. Under the ACA, the federal government will pay 100% of the costs for the expansion population from 2014 through 2016, and 90% after that time.

4. A new marketplace or "Exchange" to purchase health insurance

Taking another provision from the Massachusetts health reform plan, each state is required to set up a health insurance "Exchange." An Exchange is essentially a virtual marketplace of health plans for small employers and for individuals who don't have employer or public coverage.

California has been first to set up its Exchange (www.hbex.ca.gov), governed by an appointed board and paid for with federal funds. The Exchange is responsible for selecting plans that provide ACA-mandated "essential health benefits" at various tiers of copayments and deductibles. The consumer should be able to readily compare plans and enroll online or with the assistance of a live person. The Exchange will also calculate the premium subsidies and refer eligible persons to Medi-Cal.

The Exchange will be available in 2014 to all individuals and small employers with 50 or fewer employees. In 2016, it will open up to businesses with 100 or fewer employees.

5. Employer burdens and benefits

Starting in 2014, larger employers with 50 or more full-time equivalent employees (30+ hours a week) will be required to provide "minimum essential" and "affordable" health coverage to full-time employees (not dependents) or pay a penalty. "Minimum essential" coverage means covering 60% of the actuarial value of the cost of the benefits, and "affordable" means the premium for the coverage of the individual employee cannot exceed 9.5% of the employee's household income. The penalty is set at $2,000 per employee, after exempting penalties for the first 30 employees. Most large employers already provide health insurance, although they may have to improve the coverage to meet the "minimum essential" coverage requirements.

Since 2010, firms with fewer than 25 full-time equivalent employees have been eligible for a tax credit if they cover at least half the cost of health insurance. The full tax credit is currently 35% for firms with an average salary of $25,000, phasing out to zero when the average salary reaches $50,000. In 2014, the maximum tax credit goes up to 50%. This is a great deal for small businesses with low wages — restaurants, motels, family farmers, retail businesses, gas stations, etc.

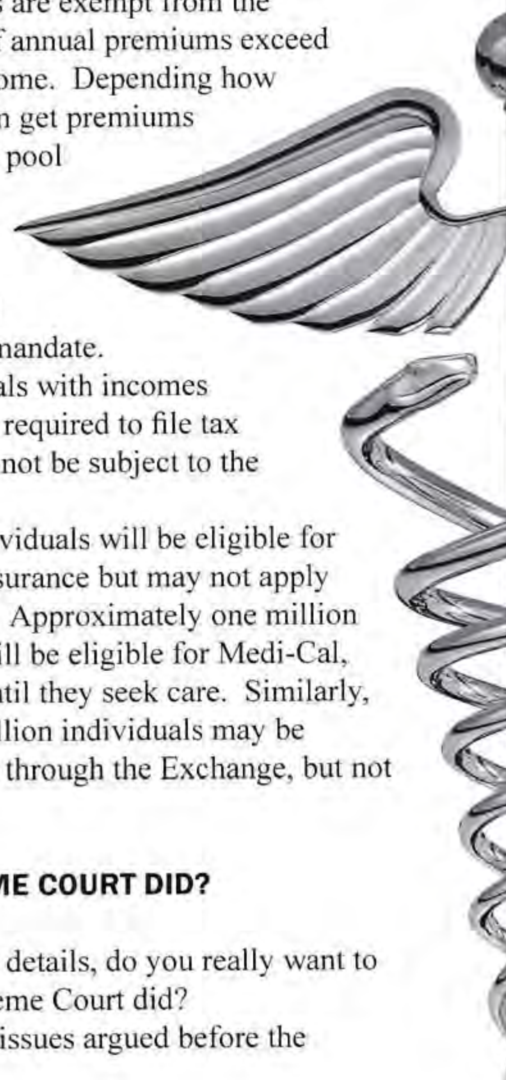
6. Who is left out?

Of the approximately eight million Californians who are without health insurance at some point during the year, approximately three to four million will remain without health insurance after the ACA is fully implemented.

How does this happen?

First, Congress specifically excluded undocumented aliens from purchasing insurance through the Exchange (even without subsidies). The undocumented also have no mandate to obtain coverage. An estimated one million undocumented persons are estimated to remain without coverage. They will continue to rely on hospital emergency rooms and safety net clinics, although they will be eligible for Medi-Cal emergency care coverage.

Second, residents are exempt from the individual mandate if annual premiums exceed 8% of household income. Depending how low the Exchange can get premiums through an expanded pool of covered persons and competition, approximately 100,000 persons will be exempt from the mandate. In addition, individuals with incomes under $9,500 are not required to file tax returns and thus will not be subject to the penalty.



Third, many individuals will be eligible for subsidized or free insurance but may not apply until the need arises. Approximately one million uninsured persons will be eligible for Medi-Cal, but may not apply until they seek care. Similarly, an additional one million individuals may be eligible for coverage through the Exchange, but not enroll.

WHAT THE SUPREME COURT DID?

So after all these details, do you really want to know what the Supreme Court did?

There were four issues argued before the Supreme Court:

1. Ripeness — was the case premature?

The Anti-Injunction Act ("AIA") prohibits litigation to enjoin or otherwise restrain the collection of taxes, thus generally requiring a person to pay a tax and then sue for a refund. If the ACA penalty under the individual mandate was a "tax" under the AIA, then the litigation was premature since the penalty did not go into effect until 2014.

The Court unanimously held that the penalty

was not a tax under the AIA and the litigation could proceed. The Court ultimately reached a seemingly contradictory decision in upholding the individual mandate as a proper exercise of the taxing power. The opinion addressed this contradiction by explaining that while Congressional nomenclature of calling it a penalty was significant for determining the applicability of a statute, it was not definitive for a constitutional determination.

2. Was the Individual Mandate constitutional?

In determining the most hotly contested provision, the individual mandate, the Court surprised many in upholding the penalty as a valid exercise of Congress' taxing authority (5-4 with Chief Justice Roberts siding with the "liberal" wing of the Court).

First, the Court held that the penalty in the individual mandate could not stand under the Commerce Clause of the US Constitution (5-4 with the Chief Justice siding with the "conservative" wing of the Court). Although Congress has broad authority to regulate commercial "activity," the majority found that the individual mandate was an attempt to regulate "inactivity" — the refusal to purchase health insurance. While the States could regulate commercial inactivity under the reserved "police power," the Court found that Congress could not.

The Court then reviewed other possible constitutional underpinnings to uphold the individual mandate. The government had indeed argued that it was a valid exercise of Congress' power to "lay and collect Taxes." The Court agreed that although Congress had labeled the tax as a penalty, a functional approach revealed that in fact it was a tax and was constitutionally sound.

3. Was the Medicaid expansion overly coercive?

Perhaps the biggest surprise came on the issue of the Medicaid expansion. None of the lower courts that heard the ACA challenges had ruled in favor of the plaintiffs' claims that the Medicaid expansion was unduly coercive. Under the ACA, if a state did not cover the expansion population, the federal government could (but was not mandated to) withhold all federal Medicaid funds. Seven justices (Ginsburg and Sotomayor dissenting) found that the coercion was akin to a "gun to the head" and that states had no real choice in accepting what was essentially a new program. However, five justices (again the Chief Justice and the liberal justices) joined together to craft a remedy and essentially made the expansion optional for the states.

A number of states have indicated that they may not participate in the Medicaid expansion. However, California will undoubtedly implement the expansion, and has already begun that process in most counties (San Luis Obispo County excepted). California counties generally support this Medicaid expansion since it will relieve them of most costs associated with their indigent care obligation in section 17000 of the Welfare and Institutions Code.

4. Were the provisions severable?

With most of the Act upheld, the Supreme Court did not reach the severability question.

WHAT NOW?

Implementation activities are intensely underway in California. The Legislature is passing authorizing legislation at a furious pace. The Exchange is in the process of developing criteria for selecting qualified health plans, defining the essential health benefits, building application systems and readying for 2014. Medi-Cal is readying for millions of new enrollees. Employers are beginning to examine the law and its impact

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on their businesses. Consumer advocates are designing outreach and enrollment systems. Hospitals are analyzing the effect of changing federal subsidies from direct hospital payments to individual insurance subsidies.

Obviously, Congressional and presidential politics can change the ACA, particularly by withholding funding for agencies charged with implementing the Act. However, many of the provisions, such as the insurance reforms, are popular and unlikely to be repealed.

There are many lingering issues. How do we find enough providers to serve newly insured? How will we really control costs? Where will the remaining uninsured get care, and who will pay? Are we ever going to solve the medical error "malpractice" conundrum?

Most of the ACA's implementation will take place in 2014, and we certainly need every minute to prepare. With the constitutional challenges behind us, the serious work can continue. While not perfect, the ACA is a great leap forward in reaching universal health care coverage. ■

HOW WILL IT AFFECT YOU?

- If you have coverage and like it — keep it.
- If you can't get coverage due to your health — you will be able to in 2014.
- If you can't afford coverage — you will get some help in 2014.
- If you have children under age 26 — put them on your policy now.
- Where do you get care? — same places as now.
- Who pays for care? — private insurance companies and public plans.
- Who pays for coverage? — very similar to current employer-based systems with public subsidies and expanded public coverage.
- As a large employer, do I "pay or play?" — you do the math, but add in nonmonetary issues such as healthy workforce, employee recruitment and retention.
- As a small employer, what's in it for me? — more insurance choices in the Exchange, and possible tax credits now.

WHY DO YOU NEED LONG TERM CARE INSURANCE?

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