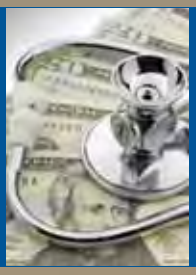

The Patient Protection and Affordable Care Act

From Theory to Boots on the Ground

ACA Critical Issues – Part I

THE PHYSICIANS FOUNDATION
Empowering Physicians
Improving Healthcare

North Carolina Medical Society
Leadership in Medicine

October 2013

The Patient Protection and Affordable Care Act From Theory to Boots on the Ground

ACA Critical Issues – Part I

Prepared by:

Bostrom

and

Old Creekside Consulting

Prepared on Behalf of

THE PHYSICIANS FOUNDATION

Physicians Committed to a Better Health Care System for All Americans

About the Physicians Foundation

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and to help facilitate the delivery of healthcare for all Americans. It pursues its mission through a variety of activities including grant-making, research and policy impact studies. Since 2005, The Foundation has awarded numerous multi-year grants totaling more than $28 million. In addition, The Foundation focuses on the following core areas: health system reform, health information technology, physician leadership, workforce needs and pilot projects. As the health system in America continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician/patient relationship and assist physicians in sustaining their medical practices during this evolution.

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ALAN WEIL, A CURRENT, UP-TO-THE-MINUTE, BREAKING NEWS, IN-DEPTH, COMPREHENSIVE ANALYSIS OF THE FIRST NINE DAYS IN THE LIFE OF HEALTH INSURANCE EXCHANGES, OCTOBER 9, 2013

ACA Critical Issues in 2014

Implementation of the Coverage Provisions of the Patient Protection and Affordable Care Act of 2010

I. The President's Legacy

A defining test of President Barack Obama's second term, and domestic policy legacy as a President of the United States, is upon the nation. Nearly three years after initial enactment in 2010, the central health insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) shifted from complex social engineering theory to "boots on the ground." These provisions are in the process of going live nationwide over the next several months.

On October 1, 2013, federal and state health insurance exchanges opened across all 50 states with varying degrees of success, and some notable failures, in their start-up execution. The deeply dysfunctional, initially at least, federal health marketplace is servicing citizens in 35 states. Those individuals and families are facing major plan shopping and enrollment challenges on Healthcare.gov, the central website for the federal exchange.

States' exchanges, participating insurers and multiple federal agencies also interact behind-the-scenes with the central federal system through the related federal data services hub. Therefore, the federal exchange's software and hardware flaws impact upon state exchanges and insurers, as well. Early alarms were sounded in Spring 2013 by private experts and the General Accountability Office that were prescient in their concerns about the adequacy of advance testing and technical readiness of the federal health exchange and data services hub.

There have been surprising setbacks in some states, as well, but genuine successes in others. None of the state setbacks are remotely the scope, level of concern, and potential impact as are the federal setbacks. Regrettably, for the millions of Americans in the process of seeking health care coverage through the exchanges, battlefield terminology seems most fitting in describing

The ACA's federal exchange challenges are a genuine "Situation Critical" moment in this Administration's domestic policy efforts.

the resulting political, fiscal and operational fallout surrounding implementation of the exchanges and the law.

To the embarrassment of the Administration, the federal exchange debut on October 1, and the critical federal data services hub has been less than stellar, giving opponents of the law ample ammunition. On October 21, President Obama announced from the Rose Garden that he was "madder than anyone" over the difficulties and technical issues of the federal health insurance exchange. The President indicated that the law was worth fighting for and that intense efforts are underway to make repairs.

Later, Kathleen Sebelius, the embattled Secretary of the federal Department of Health and Human Services, announced that Jeffrey Zients, successful entrepreneur and national Chief Performance Officer, had been "brought on board" (sent by the White House) to "provide advice and counsel" to the recovery effort, supported by an influx of experienced technology advisers from Silicon Valley and other areas of corporate America.

The ACA's federal exchange challenges are a genuine "Situation Critical" moment in this Administration's domestic policy efforts. In June 2013, the General Accountability Office had identified in a key Congressional report that 55 contractors and hundreds of millions of dollars had been committed to the effort to design the Healthcare.gov website and crucial federal data services hub. That report expressed carefully worded, but deep reservations about the progress, security readiness and testing of the technological underpinnings in both areas. Given the failures (not simply "glitches") that have occurred, every aspect of the Administration's management, capabilities and spending will be subject to harsh scrutiny by the U.S. Congress and outside critics for months to come.

Most important, the focus must remain on the central issue, which is the impact on the millions of Americans (over 20 million visits to the site reported to date) attempting unsuccessfully to shop for plans and make enrollment decisions. If the Administration is unable to rapidly and successfully re-engineer the on-line systems, and alternative enrollment approaches are inadequate, it will run-up against the open enrollment period deadlines, followed by the activation of the individual mandate requirement in 2014. As we go to press, solutions to these issues are being considered such as contracting with select state exchanges, administratively delaying the individual mandate, and extending the open enrollment period, among others. Along with the rest of America, we will be following these issues in real time.

II. The Politics

Even before the exchanges opened, an intense and prolonged political struggle was underway over the ACA's implementation and future. The de-funding of the ACA was the centerpiece of Congressional Republican and Tea Party Members' willingness to force a government shutdown effective October 1, 2013, creating major issues for the country still in the process of being addressed.

After a 16-day government shutdown, and hours before the debt-ceiling limit was to be breached on October 17, the Republicans conceded they had lost the ACA de-funding battle. The President signed a Continuing Appropriations-2014 law that only temporarily re-opens the federal government, but initiates new bi-cameral Congressional budget negotiations. We discuss the details in Chapter I on the federal budget. Be alerted, aspects of the ACA, entitlement programs, and taxes are essentially back on the table in the post-shutdown resolution agreement.

In material ways, struggles over the ACA could define the Democratic and Republican parties for years to come. The debate is equally intense across states, not just at the federal level. In ways that can't yet be foreseen, the outcome of the current political debate could affect the health care security of millions of lower and middle-income Americans. The early successes or failures of 2014, the first full year of coverage expansions under the ACA, could deeply influence the law's future, the 2014 mid-term elections, and the Presidential election in 2016.

The ACA (aka, Obamacare) is a public policy initiative that, for good or ill, will likely affect the federal government's role as an active instrument of domestic social policy for a long time to come. Over the longer-term, perhaps one or two decades or more, cooler perspectives on the evolving costs, benefits (or even continuance?) of the ACA will shape historians' views on the domestic policy legacy of the Obama Administration. Those judgments reside in the future. Our writ is to examine these issues as they are now unfolding.

III. A Historical Perspective

Looking back nearly fifty years to the origins of the Great Society programs of the 1960's, notably, Medicare and Medicaid, we find no comparably sustained opposition to a major piece of social legislation subsequent to its enactment. There was initial opposition to passage and lingering disappointment among those who objected to these major laws' specific ingredients and passage. Both of these entitlement programs continue to be the subject of frequent legislative and regulatory modifications as political, policy and budget perspectives change. Indeed, Congressman Paul Ryan, Chairman of the House Budget Committee, and now Chair of the new bi-cameral negotiating committee, has proposed major structural reforms to the Medicare program based on "premium support" concepts.

Over this timespan, we found only one instance where a notable coverage expansion law was repealed within several months of its enactment by the U.S. Congress--the Medicare Catastrophic Benefit Act, enacted in 1988 and repealed in 1989 without having been implemented. Arguably, that repeal effort was prompted more by retiree objections to certain novel, tax-code based financing provisions than to the benefit provisions. Of historical interest, first-term Senator John McCain of Arizona led the repeal effort in the U.S. Senate against the initial wishes of a number of more senior Republican Senators, who viewed him then as something of a conservative "maverick." That repealed law, while potentially worthwhile to millions of Medicare beneficiaries, was not comparable to the ACA with respect to intended scope and impact across the entire U.S. health care system.

IV. ACA Near-Term Critical Challenges

This report is focused on the central provisions of the ACA that brought the law into being—namely, the drive to expand the availability of affordable health insurance coverage to the approximately 49 million uninsured in America. Our writ is to identify

and provide perspectives on critical issues facing this implementation. As physicians know well, the ACA has extensive other health care sector provisions intended to promote population health, quality and value in patient care, cost containment, and adoption of information technology throughout the medical care system. However, this report focuses on two major coverage initiatives, state Medicaid programs and the advent of health insurance exchanges.

We highlight the following significant challenges to the early implementation of the law:

1. Sustained political opposition, federal and state
2. State decisions to not expand their Medicaid programs to the ACA

enhanced support level, creating serious coverage anomalies

3 ➤ State decisions to default to the federal exchange

4 ➤ Extensive technological challenges in the federal exchange and federal data services hub

5 ➤ Controversial Administration actions on certain ACA requirements

6 ➤ Deeply percolating legal issues winding through the federal courts

We also highlight certain physician matters:

1 ➤ Small Business Health Option (SHOP) exchanges availability for physicians who are also small employers seeking to offer health benefits

2 ➤ Network adequacy requirements for qualified health plans

3 ➤ Potential for action on Medicare issues in current budget negotiations

V. Report Structure and Looking Forward to 2014

In Chapter 1, we examine the short-term resolution of the government shutdown, review important ACA funding and other budget dynamics underlying the Congressional negotiations (already underway), and provide an Appendix with background on key budget parameters.

In Chapter II, we examine the major features and operational status of the ACA's coverage provisions rollout (exchanges and Medicaid expansions) and provide a detailed Appendix on health plan requirements, the employer and individual mandates, subsidies and other notable features.

In Chapter III, we summarize the critical ACA implementation issues and provide perspectives for physicians on select issues, identified above. Please note that there are two additional critical issues under the ACA that we defer action on until our next report, as discussed below.

We conclude by previewing two reports slated for release early in 2014 by the Physicians Foundation. The first will be released in early spring and review initial ACA coverage expansion implementation results. That report will address any significant, intervening administration or legislative actions modifying the course of implementation. It will also investigate two important issues that have not yet ripened from the standpoint of hard data for evaluation purposes.

1 ➤ RATE SHOCK—The first issue under close watch is the frequently raised concern of "rate-shock" or whether premium offerings appear excessively high or fail to meet the affordability objective. This is tied into insurer participation, numbers of offerings, and actual rates charged across different plan tiers. It is also affected by enrollee characteristics such as age, income level and subsidy interactions on premiums and cost-sharing. The market test will be actual enrollment levels in the first full open enrollment period relative to plan characteristics and enrollee characteristics. While there have been interesting attempts to both speculate on and investigate such matters while enrollment is in progress, we found such early investigations to be of limited value and not necessarily predictive of final results.

2 ➤ ADVERSE SELECTION—The second issue under close watch is whether the initial open enrollment period attracts an actuarially sound number of younger and healthier people into plans to offset the costs of older and/or less healthy enrollees. Adverse selection, that is, enrollment dominated by less healthy individuals, has profound effects on average plan costs, plan margins, and future premiums. This first year is in many ways a truly experimental year. A more crucial test could be what happens to insurer participation, plan offerings and relative premium levels in Year 2 based on Year 1 results.

Unlike the public insurance model (e.g., Medicare), the voluntary, private insurance model chosen under the ACA does not by law require all eligible people to enroll in order to ensure that there are enough healthy enrollees to cross-subsidize the costs of the

The ACA (aka, Obamacare) is a public policy initiative that, for good or ill, will likely affect the federal government's role as an active instrument of domestic social policy for a long time to come.

sick. Despite the individual mandate to carry coverage, the penalties for failure to do so are not considered to be at coercive levels relative to insurance costs. In effect, the ACA private insurance model permits market segmentation and adverse selection into plans. Our companion report to this initial one on ACA Critical Issues will examine early research and findings on these two important matters that could strongly shape the ultimate success of the private insurance model.

In closing, in 2014, the Physicians Foundation will be releasing a comprehensive report on the Medicare program. It will be released in late spring and examine the extent to which the ACA's many other health care sector objectives are being carried out through changes to the Medicare program. Medicare has long been an instrument of deep changes in the health care system because of its size and regulatory power. The ACA introduced new health care system tools and requirements into the Medicare program that, in fact, ripple way beyond services supplied to Medicare beneficiaries.

Turning to Chapter I, as we consider the progress, struggles, successes and failures of the ACA at this stage, we frequently allude to intertwined political and budget issues. Politics and budgets matter because, however imperfectly, in a representative democracy they ultimately embody our values and priorities as a nation, as manifested through the actions of our elected officials. As such, they are worthy of our attention as educated citizens. In healthcare, although they may sometimes seem remote, the activities of legislators, federal and state, materially affect physicians, the larger health care system, and most importantly, individuals, families and patients.

Chapter I ➤ A Short Take on Politics and Post-Shutdown Budget Negotiations

I. Introduction

October 2013 represented the perfect fiscal storm in the United States. The trifecta consisted of the Congressional budget process breakdown, debt ceiling limit action requirement, and partial federal government shutdown. Our goal in this chapter is not to focus on those matters, per se, but the importance and risks of the aftermath, still unfolding. There is a "fiscal storm" agreement that we summarize later that is short-term and renews the possibility of legislative action on the ACA and on entitlement programs, such as Medicare, by year's end or early 2014. It also keeps alive the possibility of another round within 3-4 months of the trifecta elements above.

The prospect of new budget agreements, ongoing ACA issues, and health care legislation occurring in short order, makes relevant recent work done for the Congress by the Congressional Budget Office and the Congressional Research Service. This work informs us about the vulnerability of different ACA funding streams, and in CBO's case, provides the legislative scoring baseline against which the fiscal impact of any new Congressional actions will be judged. First, however, the new negotiations are occurring against a very recent backdrop of important legislative actions taken at the start of 2013. We describe these briefly in the next section.

II. Recent Political and Budget History

Under the newest round of budget negotiations in the Congress, compromise on budget and policy issues with material impact on entitlement programs (e.g., Medicare physician fee schedule), or on the progress of ACA implementation remains a possibility, unless or until conclusively demonstrated otherwise. These will occur against this very recent backdrop. Looking back, in brief:

1 ➤ PASSAGE OF THE AMERICAN TAXPAYER RELIEF ACT (ATRA) OF 2012 (passed after midnight on New Year's Day), confounded orthodoxies of both parties in that it secured Republican votes for about $49 billion in new spending and offsets, and the President's support for a permanently lowered tax revenue framework. Does ATRA passage, plus the failures of recent political confrontations, presage opportunities for a budget compromise this December or will the parties adhere to the differences in their positions, leading to deeply uncharted territory? Failing in numerous ACA repeal (40 House votes) and more recent de-funding efforts, what landscape is there for a return to a semblance of normal order or a negotiation process that yields a more balanced détente? In a later section on budget perspectives, we examine one pre-shutdown assessment of multiple laws and ACA-specific fiscal arrangements guiding the effects of a government shutdown on ACA implementation. It illustrates the structural scaffolding of funding sources available to the Administration under current law.

2 ➤ STATE POWER SHIFTS IN THE 2012 ELECTIONS led to strong Republican gains in the states; namely, 30 Republican governors serving in statehouses, compared to 19 Democratic governors. Republicans gained control of about 52% of all state legislative seats, and united control of state legislatures in 25 states (Source: National Conference of State Legislators). Party affiliations and ideological differences have deeply confounded the implementation of the ACA, especially with respect to states' decisions over whether to proceed with the law's Medicaid expansion opportunities, and whether to operate state exchanges or default to federally facilitated exchanges. Default to the federal government in exchanges is viewed by many as generally contrary to states' well-guarded and historical primacy in the regulation of insurance in the United States. However, many states, primarily led by Republican governors, have exercised that choice. Politics clearly are playing a role, but so are other fiscal and programmatic flexibility concerns for states, complicating some states' decisions. We discuss these issues in Chapter II.

3 ➤ THE SEARCH FOR THE "GOVERNING MIDDLE" continues to elude the U.S. Congress (and many state governments). Our last two U.S. Healthcare Highway reports took a close look at the distinct changes in Congressional voting patterns and examined the serious implications for governance. Longitudinal analyses of voting patterns in the House and Senate make concrete that partisanship has increased and crossing party lines to engage in bipartisan cooperation has declined in real terms, across domestic and foreign policy areas. The October 2013 government shutdown was a not very surprising outgrowth of those trends. Already dim prospects for success in this latest round of negotiations are further complicated by Members' and political parties' jockeying for optimal positioning with the electorate for the 2014 off-year elections.

III. Post-2012 Election and Budget Resources

Comprehensive resources on the above matters were released in January 2013 when The Physicians Foundation published the second report in a two-part series titled the U.S. Health Care Highway—2012. It was subtitled "Part II: Crossing the Election Divide, Health Care Reform Gateway to 2013." That report took a close look at the aftermath of the 2012 elections, the resulting political and budgetary challenges and the implications for the progress of health care reform. It also detailed year-end health and tax provisions, and examined several areas of particular interest to physicians. We refer interested readers to that series and especially the second report, available on our website, for more details on data and observations which set the stage for our current discussion.

IV. The October 2013 Temporary Budget Agreement

In the waning hours of October 16th, the Senate passed a Continuing Appropriations-2014 measure by a vote of 81-18. The House of Representatives rapidly took up that

October 2013 represented the perfect fiscal storm in the United States. The trifecta consisted of the Congressional budget process breakdown, debt ceiling limit action requirement, and partial federal government shutdown.

compromise and passed it by a vote of 285-144. Of the 285 "yes" votes in the House, 87 were cast by Republicans, while the balance was cast by Democrats voting together as a bloc. The President signed the law promptly.

In brief, the federal government re-opened on Thursday, October 17. The compromise provides stopgap funding for the federal government only until January 15, 2014 and raises the debt limit only through February 17. Among other fiscal details around special certifications and an expedited Congressional disapproval process on the debt limit, the short-term funding level continues at the "sequester-reduced" levels in effect at 2013 levels (further sequester reductions would otherwise occur effective January 2014).

Under the continuing appropriations agreement, a pay raise for Members of Congress in 2014 is prohibited.

The temporary budget agreement is intended to provide a short period of time for federal budget negotiations to occur under a newly constituted, 29-Member (bipartisan, House and Senate) budget negotiation committee in the U.S. Congress. Led by the House and Senate Budget Committees' Chairs, respectively, Paul Ryan (R-MI) and Patty Murray (D-WA), the negotiating Committee is charged with reporting an agreement to their colleagues by December 13 for legislative action. Select provisions include:

1 ➤ ACA INCOME ELIGIBILITY VERIFICATION—As noted in our introduction, the Administration (via DHHS) delayed certain aspects under exchanges regarding the process for verification of individuals' eligibility for tax credits or cost-sharing subsidies, due to problems in the system by which employers would report such information to the exchanges and by which the exchanges would interact with the IRS. The Administration established temporary self-attestation and audit procedures that were strongly criticized as susceptible to fraud or abuse. The agreement requires the Secretary of DHHS to report to Congress by January 1, 2014 detailing eligibility verification procedures. The DHHS Inspector General is required to report to the Congress by July 1, 2014 on broad safeguards against fraud in the ACA generally, as well as specifically on the effectiveness of income eligibility procedures.

2 ➤ FEDERAL PAY—Back pay was awarded to furloughed federal employees, while keeping in place a general pay freeze which expires December 31. A pay raise for Members of Congress in 2014 is prohibited.

3 ➤ REIMBURSEMENTS TO STATES—Funds are awarded to states and other grantees that used their own funds to carry out federal programs or activities during the shutdown. This includes retroactive pay for furloughed state employees financed by federal funds. The Office of Management and Budget is to advise the Congress on the ultimate cost of this action.

4 ➤ OTHER PROVISIONS—Funding authorizations for a number of other provisions were included relating to non-health matters such as aviation, federal courts, highway repairs, border security, refugee assistance, and more, outside the scope of this report.

V. Re-entering the Federal Budget Fray

The government shutdown and debt limit brinkmanship of 2013 reveals the breakdown of so-called "regular order" in the U.S. Congress. This refers to the legislative process and calendar whereby Leadership, and key committees such as separate Budget and Appropriations committees in each house, as well as Senate Finance in the Senate, and Ways and Means in the House of Representatives, among others, discharge their responsibilities to develop and move the bills required to address legislative and budget matters and fund the operations of government.

Regular order in the Congress requires political and legislative discipline within the political parties, and in their actions in engaging with each other at every stage to negotiate over how best to meet the needs of the nation. Our focus is not on dissection of the political merits or lack thereof, in the budget breakdowns that have occurred. However, we think it is important to provide select factual background to inform consideration of what has occurred and to evaluate actions that are expected to occur in

the near future under the temporary federal budget agreement of October 2013.

As we go to publication in late October, the government shutdown and debt ceiling limit breach are temporarily resolved, but the federal budget impasse is not.

The shutdown cost the federal government hundreds of millions of dollars each day that it was in place. This does not include any negative impact upon the general economy or the fiscal impact upon state governments that is not totally offset by the October 16 short-term agreement and authorizations described in Chapter 1.

Separately, even another, short-term CR (through 2014?) based on current law may be contractionary, in that it may include further sequestration reductions that deepen already reduced spending levels. Other intervening events could affect political party strategies and budget decisions, such as international conflicts leading to higher, unplanned-for defense spending. All political participants will be acutely aware that the 2014 elections are approaching rapidly.

Americans can only wait for the outcome and trust that some semblance of the "governing middle" discussed in our last report will resolve at least some shorter-term issues in a less confrontational fashion. It is conceivable that the Congress and the Administration will negotiate a new CR or other budget agreement that will address shorter-term, urgent matters and push larger budgetary actions into the future. It is also conceivable that any final agreement will address issues in Medicare that are important to physicians, such as changes to the Medicare physician fee schedule's sustainable growth rate formula. We discuss this last possibility in Chapter III as we examine critical issues.

In closing, existing federal budget baseline spending and revenue projections, legislative cost scores and the financing structure of the ACA are all important in this next phase of budget negotiations. For readers with particular interest in these important budget matters, we close this chapter with an Appendix that provides select sources and details on budget considerations that will inform the negotiations. The Appendix offers useful facts about the cost of ACA repeal, funding protections around ACA subsidies and implementation funding vulnerabilities, as well as Medicare funding streams for contractor services and provider payments.

The government shutdown and debt ceiling limit breach are temporarily resolved, but the federal budget impasse is not.

Appendix to Chapter I
Re-entering the Budget Battlefield

Select Resources and Facts Informing Budget Conferees

I. Reliable, Credible Resources

As we've noted in earlier reports, the U.S. Congress acts within a framework of laws, budget requirements and legislative cost-scoring conventions. Congress also relies heavily upon the policy expertise and legal, technical and budgetary skills of professional staff in Congressionally affiliated organizations that support Members' offices, and House and Senate committees. In the health care arena, the most important resource organizations for the Congress are:

- Congressional Budget Office (CBO)
- Congressional Research Service (CRS-Library of Congress)
- Medicare Payment Advisory Commission (MedPAC)
- Medicaid and CHIP Payment and Access Commission (MACPAC)
- Congressional Joint Committee on Taxation (JCT)—Health care-related tax provisions only
- General Accountability Office (GAO)

Throughout the reconstituted 2013 budget negotiations, Members of Congress will refer to information from the sources described in this Appendix. They are particularly valued resources due to their professional standing, non-partisan orientation and fact-based approaches, and because they highlight issues of direct programmatic and legislative concern to lawmakers. Following are perspectives that help to frame certain boundaries relating to ACA implementation, as well as framing federal budget decisions that are highly politically charged.

II. Recent Congressional Budget Office (CBO) Projections Relating to the ACA, Including Repeal

One crucial question of political and budgetary consequence to some Members in current discussions is the impact on the federal budget of repealing the ACA. This interest continues despite the acknowledgement that it will not be successful in the current political configuration in the U.S. Senate and White House.

On May 15, 2013 CBO wrote to Congressman Paul Ryan in his role as Chairman of the House Budget Committee. Mr. Ryan had asked CBO to estimate the cost or savings of repealing the ACA under H.R. 45, a House bill to repeal the ACA and the follow-on provisions in the Health Care and Education Reconciliation Act of 2010.

CBO ACA Repeal Estimate

After explaining why CBO could not complete a new cost estimate timely, CBO offered the following conclusions based on prior work. Working with the Joint Committee on Taxation (JCT), *it was stated that 2012 repeal estimates would have affected direct spending and revenues in ways resulting in a net increase of budget deficits of $109 billion over the 2013-2022 budget scoring period, and it was expected that updating for a 2013 repeal would also lead to a net deficit increase of uncertain magnitude*. CBO and JCT anticipated a similar net cost of repeal result were they to update their estimates.

Total savings from repealing the insurance coverage provisions (e.g. Medicaid, HIEs, and federal subsidies) were estimated last year at $1.2 trillion. However, the costs of repealing other provisions of the ACA (cost-reducing, revenue raising) were estimated at $1.3 trillion for the 2013-2022 budget-scoring period, leading to a net increase in the federal deficit. This does not address the long-term costs or benefits of the ACA beyond the year 2022 budget window. For more on that question, see below.

CBO-Current Baseline Deficit Projections and Long-Term Health Costs

The relevant baseline for any Congressional budget action this year is largely CBO's *Updated Budget Projections: Fiscal Years 2013 to 2023,* published in May 2013. CBO has released more recent *long-term* budget projections, but this report provides the baseline for scoring of any legislation acted upon this year. In general, CBO projects federal deficits to continue to shrink from a high of 10.1 percent of GDP in 2009 (recession effects and recovery spending), and falling to a low of 2.1 percent of GDP by 2015. Revenues are rising, as well, due to the effects of ATRA, increased revenue from sources such as Fannie Mae and Freddie Mac, and rising personal income. This is positive news, but CBO cautions that there are prospects for higher deficits returning later in the decade due to pressures of an aging population, rising health care costs, an expansion of federal subsidies for health insurance and growing interest payments on the federal debt.

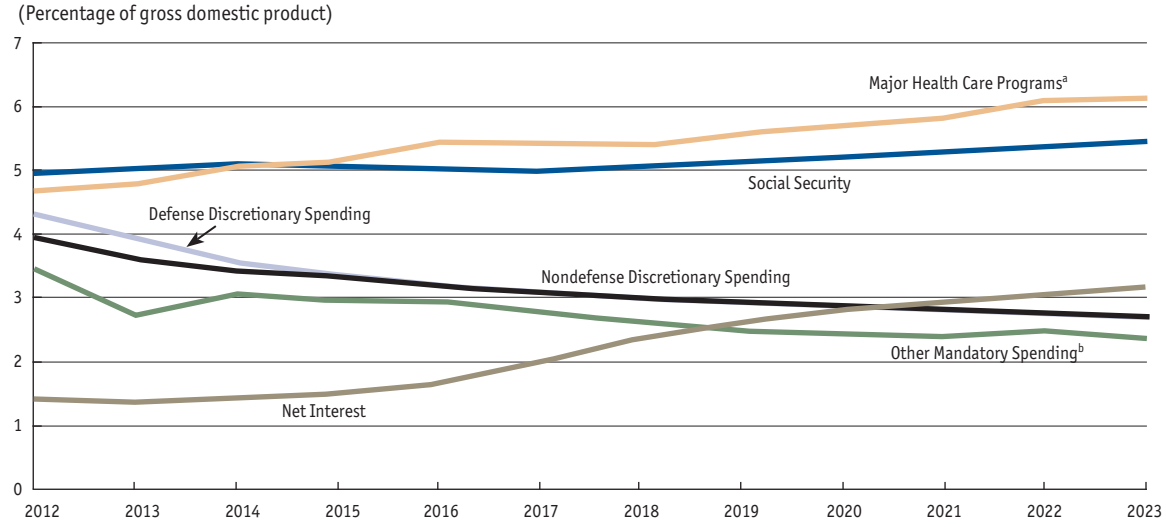
It is important to note that CBO estimates that, effective in 2014, major health care programs (Medicare, Medicaid, the Children's Health Insurance Program and subsidies offered through HIEs and related spending), will become the single biggest driver of costs in the federal budget, exceeding even the Social Security program (see CBO chart).

The longer-term cost trend of major health programs ensures that the health care entitlement programs, as well as the new sources of ACA-based spending, will continue to be prominent in federal and state budget debates. It lends growing impetus for entitlement reforms and, absent repeal, possibly for some reductions in ACA-based spending to moderate the growth trajectory. From another set of perspectives, this CBO report contains data on revenues, and sources of revenues (not summarized here), that may lend support to larger tax reform discussions already underway in the U.S. Congress. CBO's long-term budget projections highlight the fiscal value, not necessarily the practical or ideological value, of revenue increasing and spending reduction actions.

III. Congressional Research Service (CRS): Potential Effects of a Government Shutdown on Implementation of the Patient Protection and Affordable Care Act (ACA)

Although the October 2013 government shutdown has been resolved, the legal and budgetary framework surrounding the ACA is still important to understand. The budget issues have not been resolved and are back on the table for negotiation over a short timeframe. It may be reasonable to assume that a second government shutdown will not occur under the new deadlines, but it still exists as a theoretical

PROJECTED SPENDING FOR MAJOR BUDGET CATEGORIES



SOURCE: CONGRESSIONAL BUDGET OFFICE.

a. Includes medicare (net of receipts from premiums), Medicaid, The Children's Health Insurance Program, and subsidies offered through new health insurance exchanges and related spending.
b. Other than mandatory spending for major health care programs and Social Security.

possibility. Regardless, the following information is material to the budget negotiations.

Senator Tom Coburn Inquiry on Government Shutdown and ACA Implementation

On July 29, 2013, CRS released a memorandum in reply to an inquiry from Senator Tom Coburn about the potential effects of a government shutdown on implementation of the ACA. First, it was noted that there are provisions of the Constitution, legal opinions, federal budget and "anti-deficiency" statutes, and Department of Justice (DOJ) opinions that shape the parameters and exceptions of government operations during "funding gaps" caused by failure to timely enact appropriations, continuing resolutions and other budget authorizations. Entitlement programs can also be affected if program operations rely in part on annual appropriations or "discretionary" spending. For our purposes, it is helpful to simply focus on the most material points concerning ACA implementation.

CBO's long-term budget projections highlight the fiscal value, not necessarily the relative practical or ideological value, of revenue increasing and spending reduction actions.

Federal Budget Timing and Non-Performance Impact

The federal fiscal year begins on October 1 of each year. Full government functioning requires enactment of a new federal budget, or failing that, of at least a continuing resolution (CR) that extends authorized federal spending beyond that date for a specified period. Failure to do so creates a funding gap that leads to a shutdown or curtailment of an array of government activities or services (which in fact occurred on October 1). Which activities are curtailed, by what methods and to what extent depends on their legal structure, spending authorities, and availability of un-expended funds that can be tapped into to sustain programs and functions.

Impact of Government Shutdown on ACA Implementation/ACA Funding Streams

In the letter to Senator Coburn, CRS suggested that "substantial ACA implementation" would continue despite a temporary government shutdown. This would occur because 1) certain activities could continue to be performed under certain applicable federal budget laws, and 2) the government would be able to rely upon a patchwork of mandatory funds, as well as discretionary funds still available for "obligation" in various accounts. According to an excerpt from the cited communication (p. 6):

> "HHS officials expect to spend about $1.5 billion on ACA implementation in FY2013, primarily to establish the federally facilitated exchanges and related information technology (i.e., data services hub) and to conduct consumer outreach and education. In the absence of any FY2013 discretionary funding for these activities, HHS reportedly is using funds from the following sources:
>
> - approximately $235 million in unobligated HIRIF funds carried over from FY2012;
> - $454 million in mandatory funds from the Prevention and Public Health Fund (PPHF), for which ACA provided a permanent annual appropriation;
> - $450 million in no-year funds from the nonrecurring expenses fund (NEF); and
> - approximately $116 million from the Secretary's authority to transfer funds from other HHS accounts.
>
> The Administration's FY2014 budget requested $1.4 billion in new funds for CMS Program Management for ongoing ACA implementation activities, plus an additional $400 million for the IRS to administer ACA's tax-related provisions, including the premium tax credits. In the event that congressional appropriators do not provide any of these funds, or in the event of a temporary lapse in discretionary appropriations that results in a government shutdown, it seems likely that the Administration will continue to rely on alternative sources of funding to support ACA implementation activities."

Our take: This, perhaps, downplays the challenges the Administration actually faced subsequently in actions to shift funds across multiple Agency accounts. Nor does it address the reality that the original federal spending projections for implementation did not envision the costs that would be incurred by the federal government due to the unexpectedly large number of exchanges it would be operating in lieu of states in 2014. Nor did it anticipate the severe

information technology design and insufficient server capacity costs recently experienced by DHHS and which may require additional funding of some magnitude to correct. *Exchanges are to be self-sustaining in 2015 and beyond.*

IRS ACA-Related Policies and Other Agency Notes

CRS suggested the following ACA-related actions *could* occur in the Executive Branch relying upon legal doctrines, previous actions taken in non-ACA programs during previous government shutdowns, and past Executive Branch contingency plans filed by the Office of Management and Budget (OMB).

IRS Premium Credits and Cost-Sharing Subsidies

Premium credits available to low-income taxpayers enrolled in a qualified HI plan via an exchange are *permanently appropriated* under the ACA and would likely continue to be available during a government shutdown caused by lack of a timely budget agreement.

However, *health plans must reduce cost-sharing liabilities* of certain low-income individuals and families, and the Treasury is to reimburse the plans for the difference relative to what the plans actually would have cost, absent the reductions. CRS indicates it appears funds for this purpose must be annually appropriated and are at risk under a shutdown scenario, although insurers may still be required to reduce cost-sharing obligations for qualified enrollees under the ACA.

This is separate from the legal interpretation issue some have raised over whether the ACA permits such cost-sharing subsidies to be paid by the federal government, rather than states, in those states that have defaulted to federally-facilitated exchanges. The government has taken the regulatory position that it does have that authority on behalf of states in such exchanges, but litigation is ongoing and may be elevated to the Supreme Court for final adjudication.

Exchange Operations Continuance

CRS indicates funding sources outside annual discretionary appropriations are available to states and the federal government in 2014 and beyond to support exchange operations. This includes funds for the federal data services hub, other information technology requirements and consumer education and outreach. Exchanges are required to be self-sustaining in 2015, and such funds can be secured through assessment of fees on plans in the exchanges or by other means.

Individual Mandate Continuance

The ACA imposes an individual insurance mandate in the legal form of a tax penalty (codified in Sec. 5000A of the Internal Revenue Code) imposed upon individuals (taxpayers) who do not maintain "minimum essential coverage" in any given tax year. This provision is effective for calendar years beginning on and after January 1, 2014. It will be assessed as part of tax returns filed for each taxable year (e.g., for returns filed during April of the year following the taxable year, or 2015 for penalties incurred during 2014). Some groups are exempted from the mandate, and the Secretary of HHS may also grant hardship exemptions. CRS finds it likely that a government shutdown would not obviate the application or enforcement of the individual mandate and associated penalties.

Medicare payments to providers and Medicare Advantage plans

CRS cites experience from the 1995-1996 government shutdowns as *evidence that a new government shutdown would not halt payments to physicians and hospitals, as well as other providers and health plans.* Those Medicare funding sources represent mandatory spending out of the Medicare Trust Funds. However, contractors managing such claims payments for the government are paid out of appropriated accounts and could experience delays in payments until after any shutdown is resolved.

Chapter II ➤ Critical Issues Shake the Foundation of the ACA

There is a new era of federal regulation of health insurance requirements, enforceable by the federal government even in those states that are either unable to or choose not to enforce the law.

I. Overview: A New Era in Health Benefits

October 1, 2013 ushered in a new order in how health insurance plans can be offered to millions of U.S. citizens and employees of small businesses. The new, federal and state health insurance exchanges are a multi-billion dollar, high-stakes centerpiece of the ACA. The requirements under which qualified health plans are offered in a "marketplace" approach have been nearly four years in the making. The effort is accompanied by renewed issues over the size, cost and optional character of the state Medicaid programs, fraught with political debate and differing state outcomes. The resulting fragmented expansion of state Medicaid programs creates serious coverage anomalies at lower income levels relative to the law's aspirations.

Residing at the core of the law's structure and objectives is new federal oversight of the private health insurance market. For instance, private health plans must comply with certain ACA private health insurance reform requirements. Examples include coverage of minimum essential health benefits, premium reasonableness review, actuarial value of offerings, marketing standards and other requirements. These and other rules signify *there is a new era of federal regulation of health insurance requirements, enforceable by the federal government even in those states that are either unable to or choose not to enforce the law.* The ACA's federal regulatory framework, affecting health insurers, health benefits and state governments, reflects a less frequently examined incursion into the States' historic roles in regulating the "business of insurance." It represents a regulatory shift between the federal and state governments that over time may prove to be very important, but which is outside the scope of this report.

Our goal is to move directly into and streamline focus on the presentation of coverage expansion, exchange-specific requirements and critical issues. Therefore, we moved resource information on select ACA health plan requirements, individual and employer mandates, and subsidies, to an Appendix to this chapter. The balance of this Chapter assumes the reader will have some general familiarity with those concepts. First, to avoid confusion, we offer a brief word on *private* exchanges.

II. Privately Administered Employer Health Insurance Exchanges

The ACA-based exchanges are not to be confused with the privately administered insurance exchanges that have been recently gaining media attention. These have been quietly incubating in the business sector in recent years. They can be referred to as employer exchanges (ERXs) and are being organized by competing private benefit management firms, such as Towers Watson, Mercer and others.

Private exchanges are being marketed to employers as a new way to offer employer-subsidized benefit choices to their employees via a managed panel (marketplace) of competing insurance products. This is an

emerging direction in employer benefits that some industry analysts predict will grow dramatically over the next decade, spurred by the attractiveness of product choice, flexibility and personalization of benefits to employees, and to cost management for employers who can control their benefit contribution levels. Companies that have recently announced plans to move segments of their employee workforce, whether actively employed or retired, towards such exchanges include General Electric, IBM and Time Warner, Inc., among many others.

III. The ACA's Publicly Administered Exchanges

INTRODUCTION—All federal and state, ACA-based, exchanges operate within the ACA's framework of federal law and regulatory and policy requirements. The exchanges are simply (but not simple!) structured "marketplaces" through which standardized health benefit plans are offered under a specified open enrollment period. The ACA's coverage expansions are not being delivered through a uniformly designed and managed federal program such as Social Security or Medicare. Rather, the ACA seeks to build expansion of health insurance coverage upon a diverse base of 50 state Medicaid programs, supplemented by over 17,000 (in 2014 offerings) private sector health insurance plans distributed across the 50 states and offered through exchanges.

EXCHANGE MODELS—All exchanges, regardless of model, operate within the purview of the ACA's legal and operational requirements, and are subject to federal approval and oversight. Within that overarching framework, there are four exchange models:

- State-Based Exchange (SBE), under state management
- State Partnership Exchange (SPE), shares tasks with the federal government, but is considered a subset of the federally-facilitated marketplace,
- Federally-Facilitated Marketplace (FFM), under federal management, *by default under the law* (due to a state's explicit decision to default to the federal government or because the federal government declined approval of a state's exchange application), or
- Small Business Health Option or SHOP Exchange, targeted to the group market and which can be under federal or state management*

*As noted in the introduction, the FFM will not offer SHOP enrollment in the states in which it is functioning until November 1, 2013.

State exchanges follow this timeline:

- 2014-15: Must offer insurance to businesses with 2-50 employees (EEs); may include businesses with 51-100 EEs.
- 2016: Must offer to businesses with 51-100 EEs.
- 2017: May offer to larger employers (100+ EEs)

There is also a single, unified market option meaning that insurance sales are prohibited

Private health plans must comply with certain ACA private health insurance reform requirements.

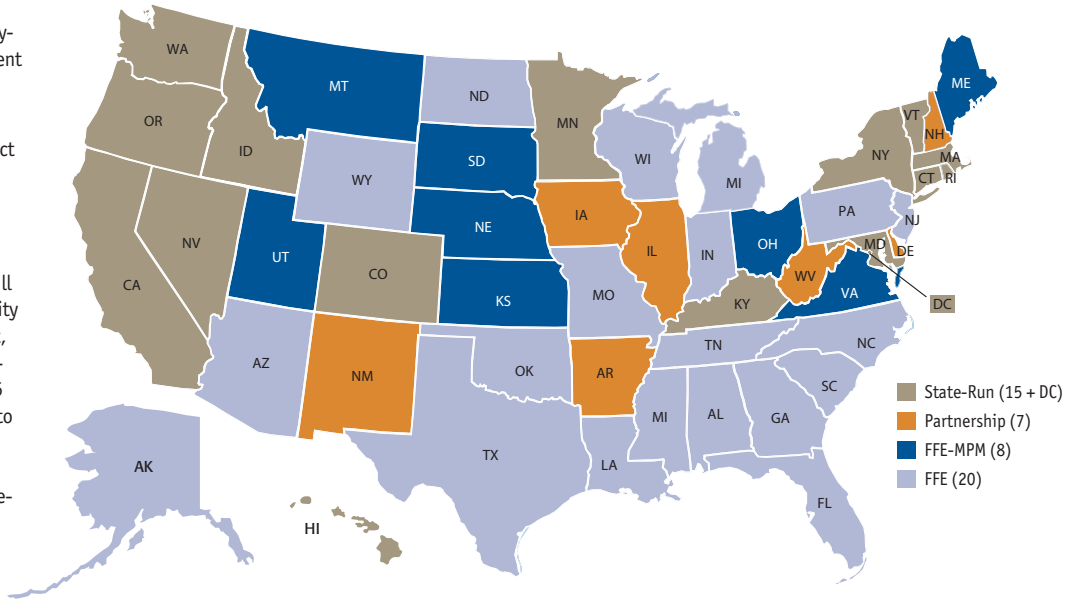
QUALIFIED HEALTH PLAN CERTIFICATION: FEDERAL REQUIREMENTS

SOURCE: ADAPTED FROM ANNE GAUTHIER; SENIOR PROGRAM DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY; PROJECT DIRECTOR, STATE HEALTH EXCHANGE LEADERSHIP NETWORK; A UNIQUELY WASHINGTON BLEND: DESIGNING AN INSURANCE EXCHANGE FOR THE EVERGREEN STATE - NATIONAL PERSPECTIVE ON EXCHANGE IMPLEMENTATION; NASHP ANNUAL CONFERENCE; SEATTLE, WA, OCTOBER 10, 2013.

2014 INSURANCE EXCHANGE OPERATIONAL MODEL

In 2014, most states are relying on the federal government for some or all exchange operational functions.

Fifteen states and the District of Columbia are operating their own individual market exchanges. In the other 35 states, the federal government will perform some or all activities, including eligibility determinations, enrollment, website operation, and consumer outreach. Of these 35 states, 15 are contributing to the exchange plan management under a partnership or marketplace plan management model.



*Utah will operate a marketplace plan management model for its individual exchange and rely on its existing small group exchange for the SHOP exchange.

**New Mexico will operate a partnership for its individual exchange, but run its own SHOP exchange.

***Although Idaho will operate a state-based exchange, it will rely on HHS for certain functions, such as eligibility and enrollment.

SOURCE: AVALERE STATE REFORM INSIGHTS, AUGUST 15, 2013

outside of the exchange. Another concept is the "employee choice" model which allows employers to offer their employees a choice of any plan offered through the exchange.

The graphic on this page displays which type of exchange is operating in each state. It should be noted that a relatively large number of states have defaulted to the federal government, generally reflecting lack of support for the ACA by either the incumbent Governor and or the state legislatures.

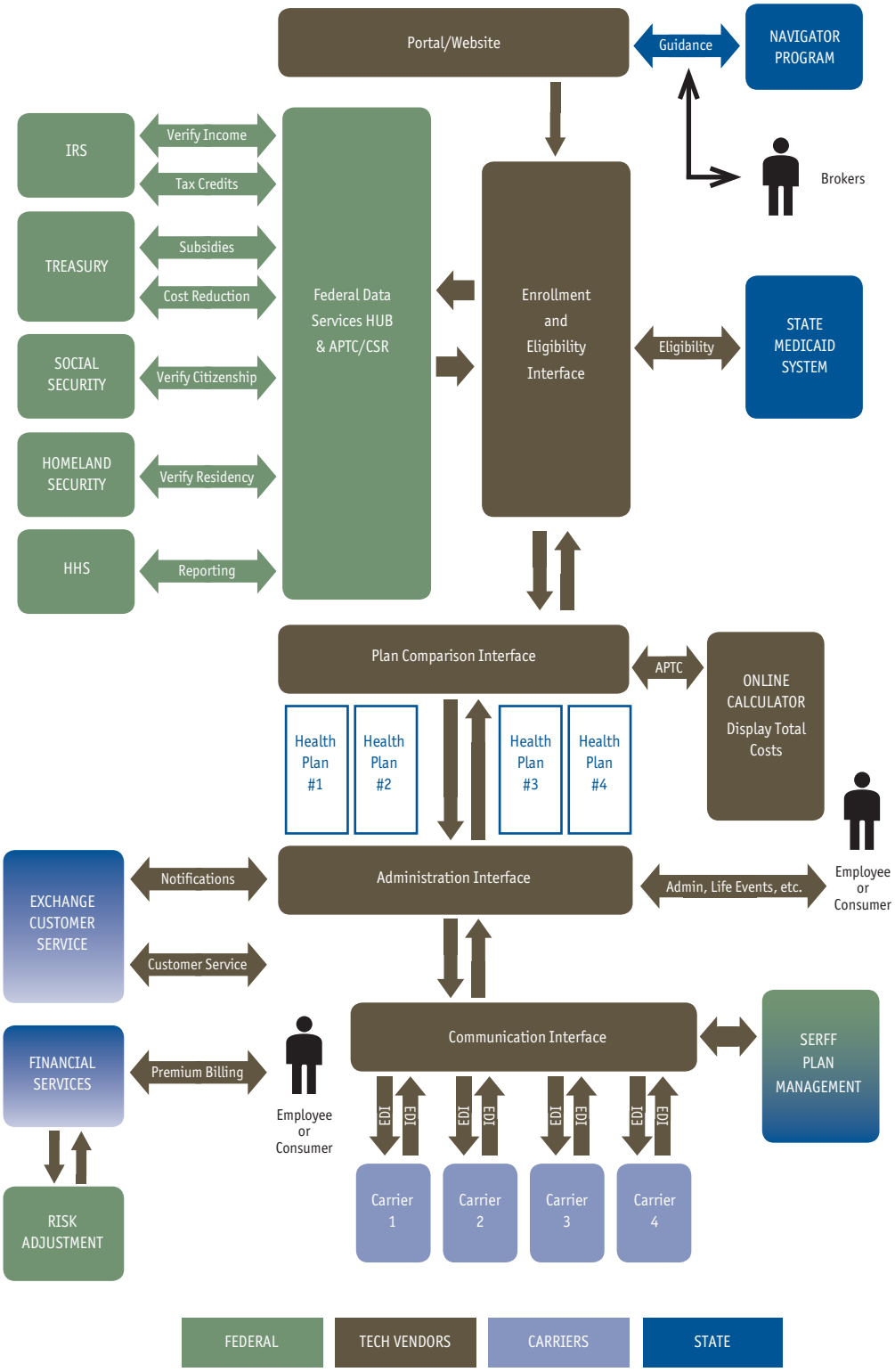
FEDERAL OVERSIGHT OF EXCHANGES—The Center for Consumer Information & Insurance Oversight (CCIIO), within CMS at the federal Department of Health and Human Services, has primary responsibility for establishing exchanges. The federal government awarded over time early innovator and large exchange planning and/or establishment grants to States at various levels to facilitate the design and establishment of exchanges, regardless of model. Even in cases where a state intended to default to the FFE, funding has been made available to address readiness for the state's Medicaid and Children's Health Insurance Plan (CHIP) programs to interact properly with the FFE, or to plan a transition from an initial FFE to a SPE or SBE exchange. Under an Implementation Advanced Planning Document process, greatly enhanced federal funds (90%) have been granted to many states to modernize their Medicaid and CHIP systems, which is a major increase in federal support over the standard 50/50 federal and state matching rates that otherwise apply.

In short, it was recognized from the very beginning that the information technology (IT) capabilities required to support exchange functions would be critical to success and a major undertaking for both states and the federal government. We'll return to this problem, but first it is important to understand the major functions of exchanges.

EXCHANGE FUNCTIONS—Exchange functions are simple to numerate, but complex to execute upon. Functions include, but are not limited to:

- Review and qualification of health plans (Must be licensed, in good standing, and meet rate, benefits, risk-adjustment, market conduct, plain language, accreditation, provider network adequacy and other requirements)
- Screen individuals for eligibility for public programs, such as Medicaid and CHIP

EXCHANGES AND DATA HUB INTERACTIONS



SOURCE: BLOOMBERG NEWS. ACCESSED ONLINE OCTOBER 2013.

The federal data hub and exchanges must interact continuously in real time to carry out major ACA functions.

Given ideological, fiscal and population cross-currents, the Medicaid expansion debate continues to be hard-fought in several states.

- Conduct enrollment in qualified health plans through the exchange
- Carry out financial management tasks
- Provide consumer assistance and accountability
- Manage a website, toll-free hotline and provide an electronic calculator that allows consumers to see their actual out-of-pocket costs after any applicable premium tax credits are applied
- Assist individuals in obtaining federally subsidized premium and cost-sharing assistance
- Interact with multiple federal agencies on select tasks, e.g. the IRS regarding employer penalties or subsidies or individual eligibility, and other agencies on citizenship or immigration status.

FEDERAL DATA SERVICES HUB—A critical component of exchange interconnectivity with federal and state agencies occurs through a data services hub (HUB). The HUB is intended to permit exchanges to interact electronically with federal and state agencies in real-time to carry out multiple information gathering and verification functions. It is a central connection for exchanges to rapidly validate social security numbers, confirm immigration or citizenship status, confirm income, determine eligibility for other federal health programs and in FFEs, allows the federal exchange to check a state resident's eligibility for or enrollment in state programs.

On the preceding page is a graphic that depicts these interrelationships, under which resides considerable technical design and support requirements.

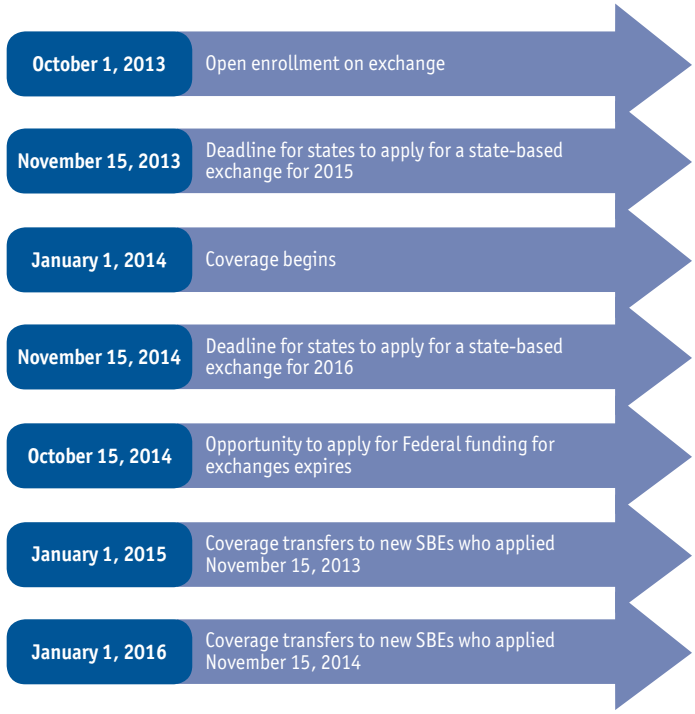
Since August 2013, CMS has pursued a series of data-sharing agreements with state administering agencies for exchanges, the IRS, the Department of Defense, the U.S. Citizenship and Immigration Services, the Veterans Health Administration, the Social Security Administration and other federal entities that regulate the data that is to be accessed and the purposes for which it can be secured to carry out the purposes of the law.

Given the information technology importance of the HUB, and the sensitivity from a privacy standpoint of the data it carries, it has generated security and implementation specifications concerns. Both the General Accountability Office and the DHHS Inspector General carried out separate reviews (June and August 2013, respectively) examining procedures and schedules undertaken for ensuring the HUB's security. Both organizations raised questions and conveyed reservations over the tight schedules and lateness of testing relative to the opening of exchanges on October 1. However, CMS issued its security authorization on September 6, 2013, certifying the HUB's readiness for operation.

NOTABLE RECENT EXCHANGE-RELATED ACTIONS—There are several recent actions taken by the federal government that are worth noting to help understand the range of activities undertaken to support the coverage rollout.

- **Final rules** were released on July 5,

KEY DEADLINES



SOURCE: ADAPTED FROM ANNE GAUTHIER; SENIOR PROGRAM DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY; PROJECT DIRECTOR, STATE HEALTH EXCHANGE LEADERSHIP NETWORK; A UNIQUELY WASHINGTON BLEND: DESIGNING AN INSURANCE EXCHANGE FOR THE EVERGREEN STATE - NATIONAL PERSPECTIVE ON EXCHANGE IMPLEMENTATION; NASHP ANNUAL CONFERENCE; SEATTLE, WA, OCTOBER 10, 2013.

2013 detailing Medicaid benefit requirements and cost-sharing, coordinated appeals process options between state exchanges, Medicaid and CHIP, electronic notices requirements for state exchanges to provide to individuals, enrollees and beneficiaries, and delaying verification by exchanges until 2015 of claims by applicants that they do not receive employer-based coverage, among other matters.

- **Final rules** were released on July12, 2013 on exchange navigators regarding training, certification, and conflict-of-interest. Hospital employees, and staff of community health centers and other health organizations are eligible to qualify as navigators, among other matters. These rules apply to FFEs and SPEs, as well as individuals in SBEs who are assisters and paid through federal grant funds.

- **Final rules** were released on August 28, 2013 establishing a number of critical provisions relating to financial integrity and oversight for exchanges, issuers and others; federal oversight of qualified health plans; consumer appeals; the navigator program; consumer payment protections; agents and broker standards and grounds for termination of agreements; and rules affecting SHOP operations.

- **On-line and Web Brokers Agreements**—CMS has executed agreements with certain online health insurance brokers to sell qualified health insurance plans in states with FFEs and in some instances, SPEs. These agreements are with eHealthInsurance.com, GetInsured.com, and the insurance broker Towers Watson. The latter will also conduct outreach efforts in select markets. eHealthInsurance.com subsequently announced a delay in providing coverage due to delays in receiving data from CMS.

CONSUMER ASSISTANCE MODELS—Despite nationwide educational efforts, in the initial open enrollment period, most consumers are expected to be unfamiliar with many details of the law's coverage requirements, exchange offerings, enrollment procedures, subsidies, and their individual responsibilities. Much has been accomplished under the law to require standardization of benefit offerings at required, pre-determined actuarial value levels, i.e., bronze, silver, gold and platinum levels. Also, essential health benefits are defined and included in every plan offering. The exchanges provide a standardized format of plan descriptions to ease comparison shopping across competing plan options.

Separately, operational steps have been taken to recognize a variety of payment methods, including for the "un-banked" or the segment of the population that does not have bank accounts, debit cards, credit cards or similar means by which to handle financial transactions in an increasingly electronic world. In addition, there are programs tailored to reaching and successfully enrolling populations whose access to or ability to properly engage with exchanges is hindered by language, education level, cultural or other barriers.

Finally, the ACA requires that exchanges establish a Navigator program. Navigators must be trained, certified, consumer-focused, avoid conflict-of-interest, and give fair, accurate, impartial" information. There are additional provisions supporting in-person application programs, and the use of licensed agents and brokers.

With this overview of exchanges, we now profile the Medicaid expansion decisions of states. Immediately following in Chapter III, we bring all these pieces together to identify several critical challenges facing the ACA going forward.

IV. State Decisions on Medicaid Program Expansion

THE STATE OF THE LAW—The U.S. Supreme Court's June 2012 decision upheld the ACA, but struck down a portion of the law that made it mandatory, rather than optional, for states to expand their Medicaid programs to 133% of the federal poverty level (FPL). In 2013, for individuals under the age of 65, this statutory level equates to a maximum annual income of $15,282 for an individual, and $31,322 for a family of four.

STATE CONCERNS—There is greatly enhanced federal financing for states that voluntarily

In Medicaid expansion, raw politics is not the whole story. States have legitimate concerns.

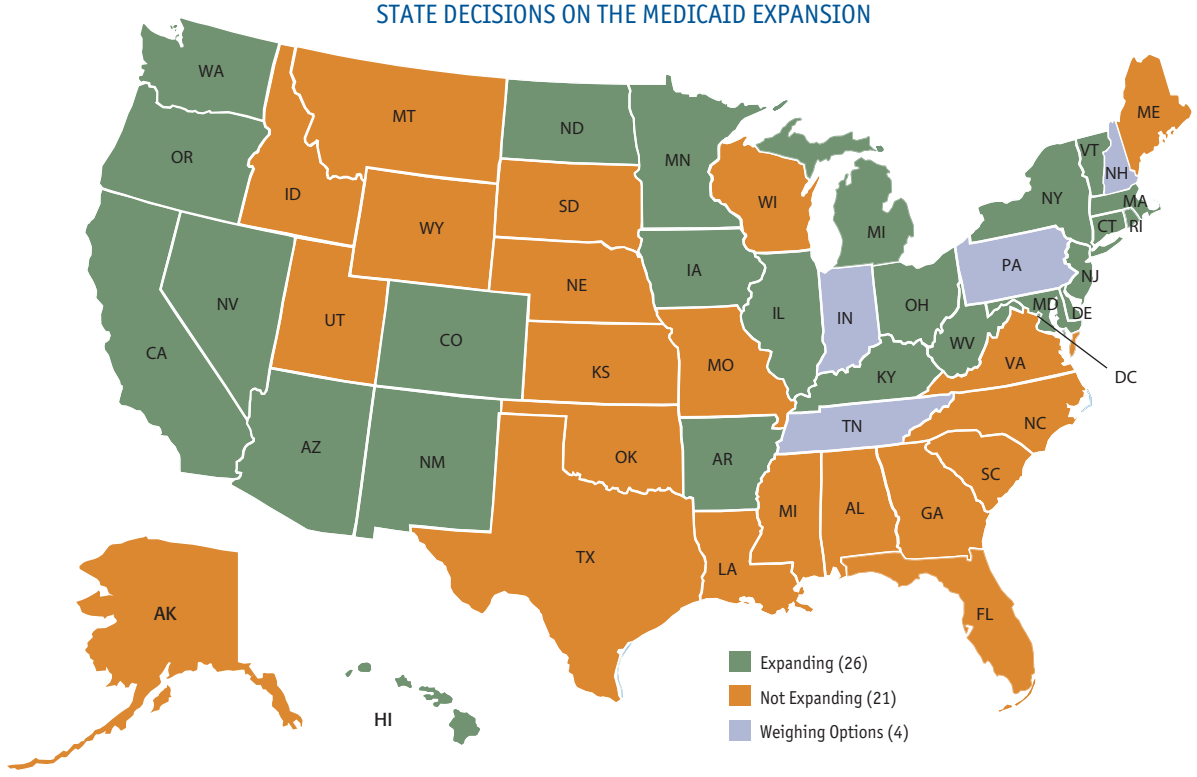
adopt the expansion (100% federal financing for the first three years, and gradual decreases thereafter until the level reaches 90% federal in 2020, where it remains unless the law is amended). Despite this highly advantageous financing, guaranteed to bring billions of dollars into states that choose to exercise the option, many states have chosen not to expand their programs.

There are complex reasons for this result. The first is clearly political, as a majority of states led by Republican governors and/or state legislatures both supported the litigation against the Medicaid expansion, and on other fronts have either voiced or actively demonstrated their opposition to the ACA. For instance, many of these same state leaders have refused to take the steps to initiate operation of a state-based or state partnership exchange, defaulting instead to the federally-facilitated marketplace. Some of these same states have refused assistance to or cooperation with the FFM as it seeks to carry out the law's default requirements to offer health plans to uninsured individuals, families and small employers in these states.

However, raw politics is not the entire story. Many states share legitimate concerns over the operational constraints and increasing costs of their Medicaid programs. For some, Medicaid cost growth has steadily outpaced growth in state revenues and budgets, crowding other priorities. It also adds to long-term state government labor, pension and other costs. There are projections, but long-term uncertainty, about the actual magnitude of the 10% share the state would be obligated to assume for the expansion population in 2020. There is also skepticism about whether the ACA-level financing shares will remain intact in the future in a federal deficit reduction era. These concerns offset the billions of dollars that could be brought into their states for the foreseeable future under current law.

Alternatively, certain long-standing federal payments to hospitals, known as

STATE DECISIONS ON THE MEDICAID EXPANSION



SOURCE: BREAKAWAY POLICY, WWW.BREAKAWAYPOLICY.COM, ONLINE ACCESS 10/18/13.

"disproportionate share of low-income patients", or DSH payments, have helped to offset the burden of uncompensated care. These payments are scheduled for steep reductions under the ACA. Not only were they a terribly inefficient and inadequate way to address the care needs of the poor and uninsured, the Congress intended that the ACA coverage expansions and improved revenues to hospitals would obviate the need for such alternative support. These payments totaled over $39 billion in 2010. Under a final rule published by CMS this past September, outlining a detailed methodology for Medicaid State DSH allotment reductions, hospitals will lose billions of dollars in DSH payments under a schedule that disregards whether the hospitals are in a state that has refused to provide for offsetting insurance coverage revenues under the Medicaid expansion.

Finally, some states have struggled with the inflexibility of the design of and federal rules governing the Medicaid program. Although various waivers and innovation options can be pursued, for many it simply is not enough. Some Governors have just recently explored blending their Medicaid program expansion with the exchange concept and sought approval to use Medicaid funds to pay premiums and enroll qualified individuals into private health plans. This is a variation on "premium support" concepts that many Republicans (and some Democrats) have supported in other settings. DHHS has shown willingness to extend such flexibility.

Given ideological, fiscal and population cross-currents, the Medicaid expansion debate continues to be hard-fought in several states. Republican Governors in MI, OH, PA, and AK, to name a few, have modified their initial opposition after reconsidering the benefits of expansion to their states. The picture is clearly evolving as states consider costs and benefits.

We turn now to Chapter III to examine both critical issues facing the ACA in the near future. We also take a look at some areas of specific concern to practicing physicians as ACA implementation proceeds and the Congressional negotiations convene on federal budget issues.

Appendix to Chapter II
A Review of Major Insurer, Individual and Employer-Related Features of the ACA

I. Overview of ACA-Based Health Insurance Market Reforms

The ACA created numerous provisions affecting the structure and offering of private health insurance in the United States. With certain exceptions for employer group plans, and whether a plan is considered to be grandfathered or not grandfathered under the law (not discussed here), these affect plans offered through exchanges and outside of exchanges. Some requirements are already in effect; more go into effect in 2014. The requirements have been summarized in two tables prepared by the Congressional Research Service. With slight modifications to simplify presentation, these reforms include pre-2014 and post-2014 requirements, summarized in charts on pages 27 and 28.

II. Other Key ACA Coverage-Related Provisions

In addition to creating new, national requirements for HIEs to be established in all 50 states, and for private health insurers and employers offering health insurance, fully effective in 2014, the ACA also created the following:

INDIVIDUAL MANDATE: There is a requirement that most individuals carry health insurance or pay an excise tax penalty.

PREMIUM AND COST-SHARING SUPPORT: There is availability of financial assistance to reduce the cost of coverage (to qualified individuals who purchase their coverage through an exchange and which can include premium tax credits and reductions of cost-sharing liabilities).

EMPLOYER MANDATE: In certain circumstances, there are penalties for employers whose plans fail to meet certain requirements.

NEW BENEFIT DEFINITIONS AND VALUATIONS FOR HI PLANS: Essential health benefits categories (10) are to be included in plans, with select limits on enrollee cost-sharing, and *there are new standards defining four levels of plan generosity based on defined percentages of average actuarial value—Bronze at 60%, Silver at 70%, Gold at 80% and Platinum at 90%. Many analysts predict the most frequently purchased level of coverage may be the Silver plans, which will cover 70% of expenses*.

TYPES OF PLANS OFFERED IN HIES: There are defined categories of plans that can be offered in HIEs, restricted to qualified health plans (QHPs), multi-state plans, consumer-operated and oriented plans (CO-OPs), Child-only QHPs, stand-alone dental plans, and catastrophic plans (limited to the non-group market).

SMALL BUSINESS HEALTH OPTIONS PROGRAM, *AKA* SHOP EXCHANGES: There are special exchange provisions to facilitate the offering of coverage by small employers (with 50 or fewer workers). Separately, there is the possibility of a small business tax credit available to employers with 10 or fewer full-time workers and where the employer's taxable wages are $25,000.00 or less. It takes different forms depending on the employer's profit status, and the employer must provide a uniform percentage of at least 50% toward the cost of their employees' health coverage.

STATE OPTIONS: a) Beginning in *2015*, at state discretion and assisted by some federal funds, states can also offer coverage to certain low-income individuals through a defined **basic health program** (BHP), b) Beginning in *2016*, two or more states can create a **"health care choice compact"** which requires both state-authorizing laws and federal approval, and c) Beginning for plan years on or after *2017*, states can apply to the federal government for **state innovation waivers** affecting certain plan qualifications, the offering of financial assistance, the individual mandate, employer penalties and even the requirement to have an exchange.

WELLNESS PROGRAMS: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains federal wellness program provisions for group health plans that allow rebates, discounts or reduced cost-

sharing inducements in wellness programs, among other requirements for such programs. The ACA allows for certain capped increases in wellness program "rewards", with options for federal approval of higher caps in the future. The ACA also provides for establishment of a 10-state pilot program not later than July 1, 2014 in which wellness provisions would be applied by participating states to insurers in the individual market.

TEMPORARY PROGRAMS EXPIRING IN 2014: Two separate temporary programs are expiring as of 2014. The Pre-existing Condition Insurance Plan (PCIP) supplemented state high-risk pools for people with pre-existing medical conditions. The Early Retiree Reinsurance Program (ERRP) assisted sponsors of participating employer-sponsored plans for a portion of their HI cost for early retirees and/or eligible dependents or spouse. Both programs will end by 2014.

PRE-2014 HI MARKET REFORMS

ACA Provision	Brief Description
Obtaining Health Insurance	
Extension of Dependent Coverage	Applicable plans that offer dependent coverage must make that coverage available to children under age 26
Prohibition of Discrimination Based on Salary	Applicable plans are prohibited from establishing eligibility criteria for full-time employees based on salary
Maintaining Health Insurance	
Prohibition on Rescissions	Applicable plans are prohibited from rescinding coverage except in cases of fraud or intentional misrepresentation
Cost of Purchasing Health Insurance	
Review of "Unreasonable" Rate Increases	Applicable plans must submit a justification for an "unreasonable" rate increase to the HHS Secretary and the relevant state prior to implementation of the increase
Covered Benefits	
Coverage of Preventive Health Services with No Cost-sharing	Applicable plans are required to provide coverage for preventive health services without cost-sharing
Coverage of Pre-existing Health Conditions – Children	Applicable plans are not allowed to exclude benefits based on pre-existing conditions for children under age 19[a]
Limits on Cost-sharing	
Prohibition on Lifetime Limits	Applicable plans are prohibited from imposing lifetime limits on the dollar value of the essential health benefits (EHB)[b]
Restricted Annual Limits	Applicable plans are restricted from imposing annual limits that fall below a specified dollar threshold on the dollar value of the EHB[c]
Other Consumer Protections	
Medical Loss Ratio (MLR) Requirement	Applicable plans are required to spend a certain amount of premium revenue on medical claims or otherwise provide rebates to policyholders
Standardized Appeals Process	Applicable plans must implement an effective appeals process for coverage determinations and claims
HHS Internet Portal	HHS is required to establish an Internet portal which will allow the public to easily search for health insurance options
Patient Protections	Applicable plans must comply with requirements related to choice of health care professionals and benefits for emergency services
Summary of Benefits and Coverage	Applicable plans must provide a summary of benefits and coverage to individuals that meets the requirements specified by the HHS Secretary
Reporting Requirements Regarding Quality of Care	Applicable plans must annually submit reports to the HHS Secretary and enrollees that address plan quality

SOURCE: CRS ANALYSIS OF ACA AND ITS IMPLEMENTING REGULATIONS.

a. Beginning in 2014, applicable plans will not be able to exclude benefits based on pre-existing conditions for anyone, regardless of age.
b. The essential health benefits (EHB) are certain benefits that all non-grandfathered health plans offered in the nongroup and small group markets will have to cover beginning in 2014. For more information about the EHB, see the "Essential Health Benefits (EHB) Package" section of this report.
c. Beginning in 2014, ACA prohibits annual limits on the dollar value of EHBs.

III. Health Insurance Coverage: New Rules Affecting Coverage, Individuals and Employers

1. Background

The goal of the ACA is to make available in all 50 states, access to a choice of comprehensive, standardized health benefits. These plans will be offered under the supervision and management of health insurance exchanges, or HIEs, operating in every state. Only qualified health plans (QHPs) meeting the standards described in the previous section (essential health services, product tiers, etc.) will be allowed to sell insurance products through the exchanges. Consumers will be allowed to choose among the tiered benefit options and determine whether the bronze, gold, silver or platinum level best meets their needs. While it is estimated there are about 49 million uninsured individuals at present in the United States, CBO estimated in its May 2013 federal baseline update that 24 million people could enroll by 2017 in health plans offered through the HIEs.

Due to historical differences in health insurance "markets" serving individuals relative to employer groups, there will be two exchanges or marketplaces in each state. There will be an exchange for individuals and a separate exchange for small employers. The latter is referred to as the "SHOP" or Small Business Health Options program, available to firms employing 50 or fewer workers. Both the individual and "small group" markets were targeted under the ACA due to historical challenges in ensuring that individuals and small employers could obtain stable, comprehensive, and affordable coverage in those markets.

2. Individual Mandate

Every individual legally within the U.S., effective in 2014, is required to carry "minimum essential health care coverage" for themselves and their dependents

POST-2014 HI MARKET REFORMS

ACA Provision	Brief Description
Obtaining Health Insurance	
Guaranteed Issue	Applicable plans are required to accept every applicant for health coverage (as long as the applicant agrees to the terms and conditions of the insurance offer)
Nondiscrimination Based on Health Status	Applicable plans are prohibited from basing eligibility for coverage on health status-related factors
Waiting period limitation	Applicable plans cannot establish a waiting period greater than 90 days
Maintaining Health Insurance	
Guaranteed Renewability	Applicable plans must renew individual coverage at the option of the policyholder, or group coverage at the option of the plan sponsor
Cost of Purchasing Health Insurance	
Rating restrictions	Applicable plans can only adjust premiums based on certain ACA-specified factors
Covered Benefits	
Coverage of Pre-existing Health Conditions – All Ages	Applicable plans are prohibited from excluding coverage for pre-existing health conditions for all individuals
Limits on Cost-sharing	
Prohibition on Annual Limits	Applicable plans are prohibited from imposing annual limits on the dollar value of the essential health benefits (EHB)[a]
Other Consumer Protections	
Nondiscrimination Regarding Clinical Trial Participation	Applicable plans cannot prohibit enrollees from participating in approved clinical trials
Nondiscrimination regarding health care providers	Applicable plans are not allowed to discriminate, with respect to participation under the plan, against health care providers acting within the scope of their license or certification

SOURCE: CRS ANALYSIS OF ACA AND ITS IMPLEMENTING REGULATIONS.

a. The essential health benefits (EHB) are certain benefits that all non-grandfathered health plans offered in the nongroup and small group markets will have to cover beginning in 2014. For more information about the EHB, see the "Essential Health Benefits (EHB) Package" section of this report.

or pay a tax penalty. The penalty proceeds in graduated levels until 2016, when it is fully in place, according to the following schedule. In each of the first three examples, the penalty is the greater of:

- In 2014—1% of applicable income, or $95.00
- In 2015—2% of applicable income, or $325.00
- In 2016—2.5% of applicable income, or $695.00
- Or, the sum of the monthly national average bronze plans for the family.

This requirement to carry coverage was upheld by the Supreme Court in its June 2012 ruling on the constitutionality of the Affordable Care Act. The penalty is construed to be a tax that is administered and enforced by the Treasury Department through a new form incorporated as part of each individual income tax return.

The following options satisfy the law's essential coverage requirements and avoid assessment of a tax penalty:

- Purchase of an individual health insurance policy,
- Purchase of coverage through a health insurance exchange,
- Enrollment in government programs, such as Medicare or Medicaid, or
- Enrollment through an employer-sponsored plan.

The Department of the Treasury (and the IRS) administers the tax credit provisions and has published multiple regulations governing their administration, including the premium tax credit affordability test. In a final rule published in June 2013, nine categories of individuals exempt from the mandate penalties were finalized.

These mandate penalty exemptions include 1) hardship situations, 2) specific groups such as Indian tribal members and dependents and 3) undocumented immigrants, 4) members of certain religious sects or ministries, 5) individuals with no plan options in their exchange, 6) individuals whose premiums are more than 8% of their household income, 7) prisoners, 8) low-income individuals in states that have opted out of the Medicaid expansion, and 9) individuals with a coverage gap of three or fewer months.

3. Individual Subsidies

In general, the ACA places limits on deductibles, co-pays and co-insurance on plans offered in exchanges. In additions, subsidies are available only for health insurance purchases inside the exchanges.

PREMIUMS—Consumers may be eligible for federal tax credits to help offset plan premiums depending on their income level and family composition. Federal subsidies are available on a sliding scale for earnings between 100% and up to 400% of the federal poverty level (FPL) to reduce premium costs. For example, in 2013, the maximum applicable FPL at 400% is $45,960.00 for an individual and $94,200.00 for a family of four. If persons are eligible for public coverage, such as Medicaid, they cannot claim the tax credit. Nor are they eligible if their employer offers them coverage *unless* their share of the premium exceeds 9.5 percent of income or if the actuarial value of the employer's plan exceeds at least 60%.

COST-SHARING LIABILITY—Cost-sharing subsidies are available for individuals earning up to 250% of the FPL. There are also limits on out-of-pocket costs for low-income individuals.

4. Employer Mandate

The ACA has established a so-called "shared responsibility provision" for large employers that average at least 50 full-time equivalent employees, or "FTEs". This is a retrospective FTE test based on business days during the preceding year. The Treasury Department and the IRS have published detailed regulations, notices and questions and answers on their health reform website. These address a variety of issues, most notably penalties that are applicable to employers under multiple circumstances, including whether or not the employer provides health coverage to employees, as follows:

- Penalties are not applicable to small employers (under 50 FTEs), if an employer fails to offer coverage to an employee's spouse or children over age 26, or during waiting periods of fewer than 90 days.
- If an employer offers coverage, and at least one FTE employee receives a premium tax credit or cost-sharing reduction, the employer is penalized the *lesser* of $3,000.00 for each employee that receives federal subsidies, or $2,000.00 per FTE (excluding the first 30 employees).
- If an employer does not offer insurance, but one or more employees receive a federal tax or cost-sharing subsidy, the employer is penalized $2,000.00 for each FTE (excluding the first 30 employees).

The Administration delayed until January 2015 the employer reporting requirements and associated penalties. This has been a politically sensitive ruling.

Chapter III

Critical ACA Implementation Challenges and Perspectives for Physicians

Overview of Critical ACA Implementation Challenges

I. What is the Fight About?

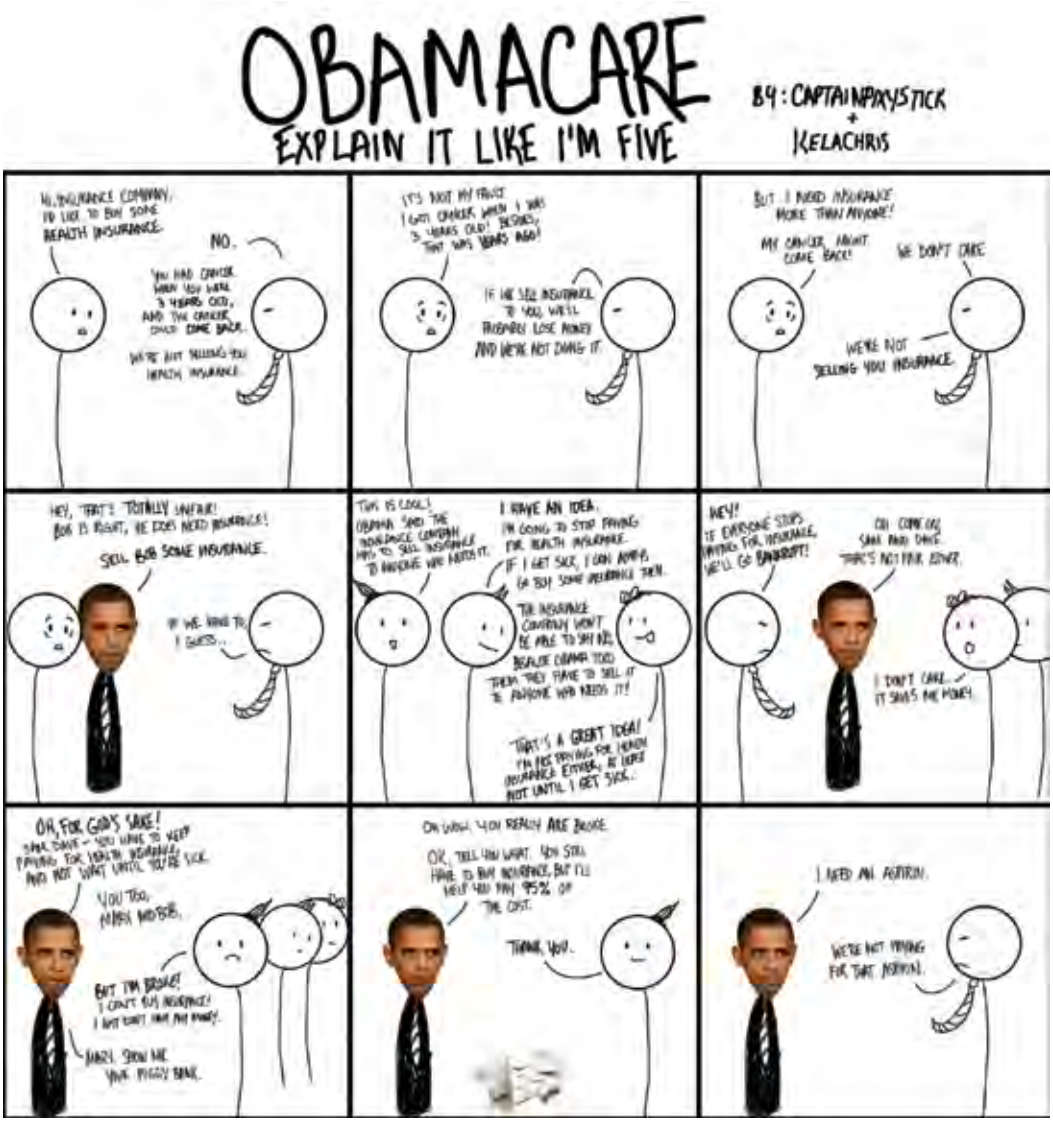
Fundamentally, the ACA is a deeply ambitious law seeking to address long-simmering concerns about deficiencies in health insurance coverage in the U.S. for millions of people, as well as health care industry cost, quality and value concerns. The coverage provisions alone create the largest new federal fiscal commitment (entitlement) to subsidized health care coverage since the advent of the Medicare and Medicaid programs in the Great Society era.

The sheer scale and the complex details have attracted the ire of many, even if they value the ACA's legislative intentions. Others are simply firmly opposed to such an activist role for government. Some value and support the law in its entirety; some support the law's objectives, but not all of the means; and, others support neither and seek outright repeal or de-funding. The public conversation about the ACA is rarely able to rest on careful distinctions about what is good, what is bad, and what should be changed and how.

Despite this polarized response to the law, we seek to examine the provisions, focus on education and facts, and assist physicians with both factual information and perspectives. In the following sections, we discuss the ACA's structural approach, its central initiatives to expand coverage, and key political and operational challenges. We then discuss select physician-oriented matters "watch-outs". We close with a look forward to work planned for 2014.

II. The ACA—The Path Not Taken

In the charged political environment surrounding the ACA, and regardless of any views on the merits of specific provisions, it is important to describe the law's coverage expansion objectives and the means chosen to accomplish those objectives. The law's length and complexity is legion. Simplification can be a thankless task, but we will try. Before wading in, a little humor to pave the way….



Returning to the messy complications of reality, the ACA was designed to be a nationally framed, but predominantly *state-managed,* expansion of health insurance coverage to millions of uninsured Americans. The coverage expansion was to be accomplished through two "legislatively dovetailed" initiatives described in the next section. These initiatives were designed under the following principles.

1 ➤ To recognize states' historic role in regulating private health insurance markets and in offering* Medicaid programs,

2 ➤ To build on the existing state Medicaid programs, and on existing private sector and employment-based health insurance benefits. Lawmakers considered, but rejected, creation of a centralized, single payer, social insurance program (referred to by some as "Medicare-for-all").

3 ➤ Lawmakers also decided against overturning the voluntary character of employers' choices in deciding whether to offer health benefits to employees. Rejecting the more restrictive employer "pay-or-play" model advanced by many on the left for over two decades, the Democrats, who were in the Majority in the House and Senate, and in the White House, enacted a paired "Medicaid expansion, plus private health insurance" model, with relatively eased, but still significant, employer benefit rules.

The ACA was designed to be a nationally framed, but predominantly *state-managed,* expansion of health insurance coverage to millions of uninsured Americans.

In crafting the ACA, lawmakers rejected a single-payer model like "Medicare-for-all."

4 ➤ The private insurance model has intrinsic elements of the private market, "premium support" concept favored in other settings by many Republicans, who were in the Minority. However, any potential support was lost over other policy decisions and procedural tactics of the Majority. The writers of the final law also created an ambitious framework around this coverage expansion model to address certain shortcomings in the private health insurance markets and broader cost, quality and information technology issues in the health care system.

5 ➤ With respect to the coverage model, the broader framework established nationally uniform requirements in each important sphere relating to the expansion of subsidized (cost to individuals) health insurance coverage in the U.S. These spheres included:

- coverage expansion parameters,
- health plan benefit and market conduct requirements,
- individual and employer responsibilities,
- exchange operations and open enrollment periods, and
- enhanced federal financing support for state Medicaid program expansions, and for income-related subsidies for the purchase through exchanges of private health insurance plans. There were numerous opportunities for improvements to the Medicaid program, as well.

*The ACA initially made mandatory States' expansion of Medicaid. This was not consistent with the optional character of states' offering of Medicaid programs in the past and was overturned by the Supreme Court in June 2012.

III. The ACA's Central Purpose

The *central purpose* of the ACA is to extend availability of affordable health insurance coverage to all eligible citizens of the United States, through two major, linked initiatives. These are:

1 ➤ **Medicaid Program Expansions:** Now at States' *option*, expansion of Medicaid program coverage in all 50 states, bolstered by greatly enhanced federal funds, to all eligible low-income individuals up to 133% of the federal poverty level (138% given a 5% income disregard), and

2 ➤ **Private Insurance Marketplaces:** Implementation of new Health Insurance Exchanges (HIEs), or private insurance marketplaces, through which an array of private health plans, accompanied by income-related subsidies, would be made available to individuals, families, and small employers seeking coverage, in all 50 states. Although these two initiatives were intended to work in a complementary fashion, they no longer do so in many states. That is discussed in the next section.

IV. Significant Near-Term ACA Challenges

We highlight the following significant challenges to the early implementation of the law:

1. Sustained political opposition, federal and state

A NATION'S POLITICAL HOUSE DIVIDED—A deeply divisive Presidential election in 2012 culminated in the re-election of President Barack Obama (ensuring continued Executive Branch implementation of the ACA), and despite some U.S. Congress re-alignments, continuation of a slightly reduced Republican majority in the House of Representatives and a Democrat majority in the Senate. Instead of Republican electoral losses (at the federal level) in 2012 tamping down opposition, there has been renewed partisan fighting in the Congressional trenches and determined challenges to the President's health care reform agenda. The fallout from the October, 2013 government shutdown, now reversed, and the implications for the next round of budget negotiations are yet to be revealed.

SUSTAINED CONSERVATIVE OPPOSITION—Without commenting on the merits, we note that with some notable exceptions, there continues to be sustained Republican and Tea Parties' opposition to the ACA in the U.S. Congress

and in statehouses (in the latter primarily those led by Republican Governors and/or legislatures). At the federal level this contributed directly to the federal government shutdown and debt ceiling limit challenges. At the state level, political opposition to the ACA has contributed to failure to expand Medicaid programs to existing and newly eligible populations in about half of the states. It has also forced the federal government to assume health insurance exchange responsibilities in many more states than ever anticipated.

CONGRESSIONAL DE-FUNDING MOVEMENT—Failing repeal of the law (40 repeal votes on record to date in the U.S. House of Representatives), there has been a sustained effort by some Congressional Republican and Tea Party members to de-fund major provisions of the ACA within the framework of the annual federal budget process. It is important to note that while some Democrats have indicated concerns about certain ACA provisions and Administration actions, none have supported the ACA repeal or de-funding efforts. In the face of concerted Democrat and Administration opposition to de-funding efforts in the Congress, political focus may pivot to more traditional federal deficit and entitlement program reforms. This does not rule out modification of select ACA provisions in any upcoming budget agreement. Some Members continue to hold out the threat of a second government shutdown.

2. States' decisions to not expand their Medicaid programs to the ACA enhanced support level, creating serious coverage anomalies

➤ **SEAMLESS COVERAGE EXPANSION SUNDERED**—As noted earlier, the two central coverage provisions, Medicaid program expansions and subsidized private plan coverage, were "legislatively dovetailed" and intended to work together. Eligibility for federal subsidies in exchanges was pegged in the law to a level just above the top income threshold (138% of the Federal Poverty Level or FPL) where Medicaid expansion eligibility ceased. This dovetailing of eligibility was intended to ensure seamless coverage and affordability measures across income levels.

➤ The "seamlessness" of the law's original eligibility and coverage provisions was effectively sundered under the Supreme Court's June 2012 decision declaring that Medicaid expansion under the ACA could only be optional to, not mandatory upon, the states. It has led to coverage availability gaps for millions of people in the states that have chosen to not expand their Medicaid programs. This has been a serious blow to the law's central purpose.As we noted in Chapter II, such states are leaving literally billions of federal dollars on the table as a result.

➤ Recent research suggests about 5-7 million poor people in those states who could be covered under Medicaid expansions will go without coverage, and due to structural elements in the law are also disadvantaged in coverage or subsidy eligibility in their state's exchange. In the non-expansion states, several Republican Governors have overcome opposition or are continuing to actively explore their Medicaid expansion options. DHHS flexibility on the programmatic form the Medicaid expansions take is aiding reconsideration in some states. An example is mechanisms to use Medicaid funds to purchase private coverage in the exchanges for select Medicaid-eligible individuals, with some benefit adjustments.

3. State decisions to default to the federal exchange

➤ **FEDERAL EXCHANGE DEFAULT OPTION TURNED TO LEAD ROLE**—Along with the expanded Medicaid programs, the HI exchanges were expected to be largely state-directed, with both forms of coverage expansion dovetailing to prevent eligibility gaps. Insurance offerings across exchanges would occur within an over-arching national framework that provided consistency in key requirements across all states.

➤ The federally-directed HIE *default* option was provided in the ACA only in those instances where states chose not to operate their own health insurance exchanges or simply could not satisfy the law's exchange requirements. Federally managed health insurance exchanges were expected by the U.S. Congress to be rare, perhaps even non-existent. It was widely

Federally managed health insurance exchanges were expected by the U.S. Congress to be rare, perhaps even non-existent.

assumed that states would be loath to have the federal government engaged so deeply in highly pre-emptive state-level activities.

➤ As of this writing, 35 states have completely or partially defaulted to the federally-facilitated marketplace (FFM). The fiscal costs, management complexity and challenges for the federal government of undertaking these responsibilities across so many states cannot be overstated. It is unclear how big a role the unanticipated scale of the FFM activities, and lack of cooperation in some states where linkages to state programs and systems are essential, may be playing in exacerbating the technological and data interchange issues plaguing the FFM.

4. Extensive technological challenges in the FFE and federal data services hub

➤ **SCALE AND EXECUTION CHALLENGES IN THE FEDERAL MARKETPLACE**—The ACA is the largest social welfare program enacted in the United States since the 1964-1965 Great Society Programs era marking enactment of the Medicare and Medicaid programs. There are enormous start-up costs and thousands of operational tasks underway in the Administration and in states, costing several billion dollars, federal and state, to launch the health insurance exchanges. Billions more will be spent on Medicaid program expansions even though a number of states have chosen not to expand their Medicaid programs. The sheer magnitude of the collective health insurance coverage effort, and deep software design and hardware capacity challenges in the initial exchange launches, has led to controversial delays in some provisions and operational vulnerabilities in the initial open enrollment processes.

➤ There has been extensive media coverage of the technical and operational failures in the federal Healthcare.gov website and the more hidden technical channel communications that must occur between agencies and insurers behind the scenes. As we noted in Chapter II, a critical component of exchange interconnectivity with federal and state agencies occurs through the federal data services hub (HUB). The HUB is intended

to permit exchanges to interact electronically with federal and state agencies in real-time to carry out multiple information gathering and verification functions. It is a central connection for exchanges to rapidly validate social security numbers, confirm immigration or citizenship status, confirm income, determine eligibility for other federal health programs and in FFEs, allows the federal exchange to check a state resident's eligibility for, or enrollment in, state programs.

➤ At present, there are serious design flaws in the "front-end" federal website that permits shopping for and enrollment in health plans. These are greatly impeding the ability of millions of individuals to acquaint themselves with what the law could do for them and to make coverage decisions. There is great concern that this could suppress enrollment. There are apparently equally troubling failures in the critical "back-end" data interactions that need to occur through the HUB described above. States and insurers are reporting significant delays in processing applications based on data from the FFE and are experiencing high error rates.

➤ The GAO issued a report in June 2013 titled *PPACA, Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges (GAO-13-601)*. That report is among the best resources to date detailing the challenges, contract awards, and technological issues of the FFE. Upcoming Congressional oversight hearings will update this information. In its report, GAO expressed great reservations about the preparedness, security and testing of the FFE systems, and can be expected to report further to the Congress on the evolving issues and prospects for timely solutions. More information will emerge shortly as federal officials and contractors testify in Congressional oversight hearings. A key issue to monitor in the federal exchange issues will be the timing of solutions for individuals and families relative to the open enrollment period deadlines and the individual mandate penalty for failure to secure insurance timely. The Administration is investigating its authority for administrative remedies on modifying the individual mandate, such as invoking the hardship exemption.

V. Controversial Implementation Exceptions

Following are Administration-sponsored actions to modify ACA programs or implementation progress due to poor legislative design or operational difficulties. They are important, but their sensitivity has been eclipsed by the issues we described above.

The most notable to date are:

➤ **CLASS ACT REPEAL**—The first major ACA legislative failure was not a delay, but a rout. The Administration made an early determination that the Community Living Assistance Services and Supports (CLASS) Act portion of the law establishing a national program for long-term care benefits was structurally and actuarially unsound. This led to a) an Administration announcement that the CLASS Act portion of the law could and would not be implemented in the form in which it was legislated, b) the subsequent repeal by the Congress of that section of the ACA, and c) the formation of a Long-Term Care Task Force charged with re-examining the nation's long-term care issues and options. The Task Force released recommendations this Fall, but they are advisory and leave deeply unsettled any progress on the growing issues of long-term health care in an aging population. This history exposes the gap that can exist between legislating policy and its effective implementation.

➤ **EMPLOYER MANDATE ONE-YEAR TRANSITIONAL DELAY**—A more recent, and controversial, exception to ACA requirements was the federal Department of the Treasury's surprise announcement in July 2013 that it was delaying the employer penalty and mandate provisions of the law for one year in order to simplify and finalize reporting requirements. This led to calls for also delaying the individual mandate, the requirement that all citizens must have health insurance coverage in or pay a tax penalty. On July 30, 2013 CBO wrote to Congressman Paul Ryan regarding the details behind the Administration's actions and the budget impact. CBO estimated that the net budget period (2014-2023) cost in coverage provisions would be an increase of $12 billion more than previously estimated.

A key issue to monitor in the federal exchange issues will be the timing of solutions for individuals and families relative to the open enrollment period deadlines and the individual mandate penalty for failure to secure insurance timely.

➤ **PARTIAL LIFTING OF LIMIT ON CATASTROPHIC COSTS FOR INDIVIDUALS**—Shortly afterword, an *earlier*, unannounced Spring 2013 decision to relax insurer out-of-pocket payment limits for a subset of individuals if they were enrolled in select plans facing benefit coordination issues, became more public and was also subject to criticism.

VI. Legal Challenges to Select ACA Provisions

➤ **SUBTERRANEAN LEGAL RISKS TO ACA FRAMEWORK**—It is important to be aware there is significant ongoing litigation on issues such as the judicial interpretation of the legal availability of crucial federal subsidies in states served by federal exchanges, and separate requirements for provision of contraceptive benefits in health plans. Analysis of these cases is outside the scope of this report. However, as lawsuits against key ACA features are being litigated and as decisions are rendered, major new fault lines could appear to challenge the shape and future of the law in 2014.

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VII. Physician Issues

We close by highlighting certain physician matters:

1. Small Business Health Option (SHOP) exchanges for physicians who are also small employers seeking to offer health benefits

➤ As noted in Chapter II, the ACA provides businesses with fewer than 50 employees the opportunity to buy group insurance plans through SHOP exchanges. This provision was designed to address small-group market affordability and stability issues by creating qualified health plan (QHP) competition in this space and by spreading risk across small businesses. Under SHOP, there are two models: 1) Employer choice where the employer chooses one plan for his or her business from all the available QHPs, or 2) Employee choice where employees choose their plans individually from all the available QHPs.

➤ CMS issued final rules on June 4, 2013. Those rules delay the availability of the employee choice model in the FFM and state partnership exchanges until January 1, 2015. The employer choice model remains available for January 1 2014, but enrollment may not be available until November 1, 2013.

➤ There are 17 states implementing state-based SHOP exchanges. Interested physician employers should check their state SHOP exchange to determine what kind of exchange is operating and which small business options are being made available in 2014 in their state. A 50-state chart providing information on how to access each state's exchange resources appears at the end of this chapter.

2. Network adequacy requirements for qualified health plans

➤ Among the requirements that qualified health plans must meet is a standard specifying provider network adequacy supporting offerings of qualified health plans. It is the responsibility of the exchange qualifying the health plans to ensure this standard is being met.

3. Potential for action on Medicare fee schedule in budget negotiations

➤ In the aftermath of the October government shutdown, a bi-cameral, bi-partisan budget negotiation committee was established in the Congress that is required to report by December 13, 2013. Pent-up entitlement program, tax reform and other issues are in the mix. Legislative actions could occur under the unfolding federal budget negotiations that could lead to changes affecting physicians.

➤ Legislative action could be taken to modify the Medicare sustainable growth formula in the physician fee schedule, and to address the perennial issues of payment reductions in the annual, calendar year, fee schedule updates. Most physicians are aware that the House Ways and Means Committee and the House Energy and Commerce Committee, as well as the Senate Finance Committee have done considerable work in 2013 reviewing SGR issues and formulating options for change. Working papers were released to the industry

during the year and have been commented upon extensively by national and state medical associations and specialty societies. We urge physicians to contact their representative organizations, as needed to stay abreast of this matter over the next several weeks.

VIII. Conclusion

We conclude by previewing two reports slated for release early in 2014 by the Physicians Foundation. The first is a follow-on report to this one. It will be released in early spring and review initial ACA coverage expansion implementation results. It will address any significant, intervening administration or legislative actions modifying the course of implementation. It will also investigate two important issues that have not yet ripened from the standpoint of hard data for evaluation purposes.

➤ **RATE SHOCK**—The first issue under close watch is the frequently raised concern of "rate-shock" or whether premium offerings appear excessively high or fail to meet the affordability objective. This is tied into insurer participation, numbers of offerings, and actual rates charged across different plan tiers. It is also affected by enrollee characteristics such as age, income level and subsidy interactions on premiums and costsharing. The market test will be actual enrollment levels in the first full open enrollment period relative to plan characteristics and enrollee characteristics. While there have been interesting attempts to both speculate on and investigate such matters while enrollment is in progress, we found such early investigations to be of limited value and not necessarily predictive of final results.

➤ **ADVERSE SELECTION**—The second issue under close watch is whether the initial open enrollment period attracts an actuarially sound number of younger and healthier people into plans to offset the costs of older and/or less healthy enrollees. Adverse selection, that is, enrollment dominated by less healthy individuals, has profound effects on average plan costs, plan margins, and future premiums. This first year is in many ways a truly experimental year. A more crucial test could be what happens to insurer participation, plan offerings and relative premium levels in Year 2 based on Year 1 results.

Unlike the public insurance model (e.g., Medicare), the voluntary, private insurance model chosen under the ACA does not by law require all eligible people to enroll in order to ensure that there are enough healthy enrollees to cross-subsidize the costs of the sick. Despite the individual mandate to carry coverage, the penalties for failure to do so are not considered to be at coercive levels relative to insurance costs. In effect, the ACA private insurance model permits market segmentation and adverse selection into plans. Our companion report to this initial one on ACA Critical Issues will examine early research and findings on these two important matters that could strongly shape the ultimate success of the private insurance model.

Finally, in 2014, the Physicians Foundation will be releasing a comprehensive report on the Medicare program. It will examine the extent to which the ACA's many other health care sector objectives are being carried out through changes to the Medicare program. Medicare has long been an instrument of deep changes in the health care system because of its size and regulatory power. The ACA introduced new health care system tools and requirements into the Medicare program that, in fact, ripple way beyond services supplied to Medicare beneficiaries. In our view, the Medicare program has been a significant source of "social engineering" in the American health care system since its inception. The ACA deepened greatly the scope of such efforts through its extensive new provisions in Medicare. That report is scheduled for release in the second quarter of 2014.

As always, we thank you for your time and attention.

A 50-state chart providing information on how to access each state's exchange resources appears at the end of this chapter.

STATE HEALTH INSURANCE EXCHANGE WEBSITES

**Chart Updated October 7, 2013*

When open enrollment begins on October 1, consumers will be able to select and purchase health coverage online through a state-based exchange or the federal marketplace. This chart provides useful links to the web portals, where consumers can purchase coverage, as well as links to relevant agency websites containing exchange policy and consumer assistance-related information.

Like all State Refor(u)m research, this chart is a collaborative effort with you, the user. State Refor(u)m captures the health reform comments, documents, and links submitted by health policy thinkers and doers all over the country. And our team periodically supplements, analyzes, and compiles this key content.

Know of something we should add to this compilation? Eager to update a fact we've included? Your feedback is central to our ongoing, real-time analytical process, so tell us in a comment, or email the author with your suggestion. She can be reached at rdolan@nashp.org.

State	Model	Consumer Portal[1]	Exchange or Relevant Agency Website[2]	Exchange Call Center Phone Number[3]
		Where consumers will shop for health insurance	*Reference site for policy documents or additional health reform information*	*Phone number for consumer call center.*
AL	FFM	Healthcare.gov	AL Health Insurance Reform Information Center	800-318-2596
AK	FFM	Healthcare.gov	AK Affordable Care Act webpage	800-318-2596
AZ	FFM	Healthcare.gov	AZ Health Insurance Exchange webpage	800-318-2596
AR	SPM	Healthcare.gov	AR Health Connector	800-318-2596
CA	SBE	Covered California	CA Health Benefit Exchange	800-300-1506 / 800-300-0213 (Spanish)
CO	SBE	Connect for Health Colorado	Connect for Health Colorado	855-PLANS-4-YOU / 855-752-6749
CT	SBE	Access Health CT	Access Health CT	855-805-HEALTH / 855-805-4325
DC	SBE	DC Health Link	DC Exchange	855-532-LINK / 855-532-5465
DE	SPM	Healthcare.gov	Choose Health DE	800-318-2596
FL	FFM	Healthcare.gov	FL Federal Health Care Insurance Reform webpage	800-318-2596
GA	FFM	Healthcare.gov		800-318-2596
HI	SBE	Hawaii Health Connector	Hawaii Health Connector	877-628-5076
ID	SBE	Your Health Idaho	Your Health Idaho	855-YHIdaho / 855-944-3246
IL	SPM	Healthcare.gov	Get Covered Illinois	800-318-2596
IN	FFM	Healthcare.gov	IN ACA webpage	800-318-2596
IA	SPM	Healthcare.gov	IA Health Benefit Exchange	800-318-2596
KS	FFM	Healthcare.gov	KS Health Insurance website	800-318-2596
KY	SBE	Kynect	Kynect	855-4kynect / 855-459-6328
LA	FFM	Healthcare.gov	LA Health Care Reform Resource Center	800-318-2596
ME	FFM	Healthcare.gov	ME Federal Health Care Reform webpage	800-318-2596
MD	SBE	Maryland Health Connection	MD Health Benefit Exchange	855-642-8572
MA	SBE	Massachusetts Health Connector	Massachusetts Health Connector	877-MA-ENROLL / 877-623-6765
MI	FFM	Healthcare.gov	MI Health Insurance Consumer Assistance Program	800-318-2596
MN	SBE	MNsure	MNsure	855-3MNSURE / 855-366-7873
MS	FFM	Healthcare.gov	MS Health Care Reform page	800-318-2596
MO	FFM	Healthcare.gov		800-318-2596
MT	FFM	Healthcare.gov	MT Health Answers	800-318-2596
NE	FFM	Healthcare.gov	NE Federal Health Care Law page	800-318-2596
NV	SBE	Nevada Health Link	NV Exchange	855-7-NVLINK / 855 768 5465
NH	SPM	Healthcare.gov	NH Health Exchange Planning website	800-318-2596
NJ	FFM	Healthcare.gov	NJ Federal Health Coverage Law page	800-318-2596
NM	SBE	Be Well NM	NM Health Insurance Exchange	855-99-NMHIX / 855-996-6449
NY	SBE	NY State of Health	NY Health Reform	855-355-5777
NC	FFM	Healthcare.gov	Federal Health Care Reform in NC	800-318-2596
ND	FFM	Healthcare.gov	ND Health Care Reform page	800-318-2596
OH	FFM	Healthcare.gov	OH Health Care Reform webpage	800-318-2596
OK	FFM	Healthcare.gov		800-318-2596
OR	SBE	Cover Oregon	Cover Oregon	855-CoverOR / 855-268-3767
PA	FFM	Healthcare.gov	PA Federal Health Care Reform webpage	800-318-2596
RI	SBE	Health Source RI	Health Source RI	855-840-HSRI / 855-840-4774
SC	FFM	Healthcare.gov	SC Health Insurance Marketplace webpage	800-318-2596
SD	FFM	Healthcare.gov	SD Health Care Reform webpage	800-318-2596
TN	FFM	Healthcare.gov	TN Health Insurance webpage	800-318-2596
TX	FFM	Healthcare.gov	TX Federal Health Care Reform Resource webpage	800-318-2596
UT	FFM	Healthcare.gov	UT Federal Health Reform webpage	800-318-2596
UT	FFM	Avenue H	UT Small Business Exchange	800-318-2596
VT	SBE	Vermont Health Connect	Vermont Health Connect	855-899-9600
VA	FFM	Healthcare.gov	VA Health Reform webpage	800-318-2596
WA	SBE	Washington Healthplanfinder	WA Health Benefit Exchange	855-WAFINDER / 855-923-4633
WV	SPM	Healthcare.gov	WV Health Policy Unit	800-318-2596
WI	FFM	Healthcare.gov	WI Health Care Reform webpage	800-318-2596
WY	FFM	Healthcare.gov	WY Department of Insurance ACA webpage	800-318-2596

[1] For state benefit exchanges, the 'Consumer Portal' link goes direct to the consumer portal for the state exchange; for SPM and FFM exchanges, the link goes to the federal portal.

[2] Links to a state exchange policy/board site, where applicable, or to a state health reform or consumer assistance webpage.

[3] Phone number for the main call center to assist consumers.

Chart produced by Rachel Dolan and Leo Quigley

See more at www.statereforum.org/state-exchange-websites#sthash.kmXJms8b.dpuf

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