Affordable Care Act: Controversial History

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Since its inception the Affordable Care Act (ACA), P.L. 111-148, has been a controversial effort. It found its roots in rising healthcare costs, and primarily European efforts to both contain costs and provide coverage for all through "universal coverage" or "universal access" models. American legislation started at the state level, with several expanded healthcare coverage plans which were delivered by applying Medicaid waivers (Section 1115).

Healthcare Reform Need

Entering the century it was widely recognized that America had the world's best health care, however it was also widely believed that the system was soon to be in crisis. Ever since World War II, the cornerstone of U.S. health care finance had been employer-based insurance. However, as the last century drew to a close fewer U.S. firms enjoyed healthy profits that could be drawn upon to subsidize health insurance for their workers, several factors led to this including the growth of foreign investment, and changes in regulation.[1]

The U.S. healthcare spend was escalating rapidly, with excessive administrative costs, and a growth in reported medical errors (including overuse and underuse of medications and procedures).[2]

Another growth factor was the projected aging of the U.S. population, the number of people in the oldest age group (those aged 85 and over), is projected to grow from 5.9 million in 2012 to 8.9 million in 2030. In 2050, this group is projected to reach 18 million. In 2050, those aged 85 and over are projected to account for 4.5 percent of the U.S. population, up from 2.5 percent in 2030.[3] Also at issue, were the numbers of Americans lacking coverage. The Census Bureau's long-term Survey of Income and Program Participation found that 27.6 million people were without insurance for the entire year in 2005, and 65.9 million were uninsured for at least one month during the year.

Policymakers that sought to address these issues, in the last decade, faced two basic questions: Should reform be incremental or comprehensive? And should it focus first on care financing or delivery of care?

Addressing healthcare reform was a delicate balancing act, undertaking a massive industry with an enormous scope and interlocking segments that have evolved over a long time. Most Americans see only the relationship they have with their physician or perhaps their pharmacist. However, behind that relationship exists a behemoth, including an array of medical groups, insurers, and others.

The healthcare industry broadly defined includes a wide range of businesses: drug manufacturers, including pharmaceuticals and biotechnology; diagnostics and device manufacturers; hospitals; physician groups; individual providers; insurance providers; and health technology and information providers.[4] Added to the industry itself, of course, is government (at the federal level that includes: CMS (Medicare, Medicaid), military healthcare, Veteran's Affairs, Food and Drug Administration, and others).

State Efforts before the ACA

Many states attempted to address healthcare reform on their own terms before passage of the ACA. By and large they attempted this utilizing a section of the Social Security Act of 1962, specifically Section 1115. That section allows the Secretary of the US Department of Health and Human Services (HHS) to waive certain legal provisions of its programs, including Medicaid. Enabling states to apply for these waivers enabled the executive branch to promote innovation, improvement, and possible efficiencies in health care service delivery. States with 1115 waivers received federal matching funds to expand Medicaid services and eligibility requirements. The State Children's Health Insurance Program (S-CHIP, later CHIP) was enacted in 1997 and was fully implemented by 2000. CHIP contributed to an increase in Medicaid enrollment, as many families of children who responded to the program's outreach efforts were found to be eligible for Medicaid. Health care spending also began to increase at faster rates, particularly for prescription drugs. In 2001, the Bush (43) administration newly permitted the use of CHIP funds to cover childless adults. However, the Congress barred future CHIP waivers for childless adults under the Deficit Reduction Act (DRA). Section 1115 waiver initiative process came into being, Health Insurance Flexibility and Accountability (HIFA), allowing states to demonstrate comprehensive state approaches that would increase the number of individuals with health insurance coverage using then-current-level Medicaid and CHIP resources.[5]

Upon the implementation of the ACA, Section 1115 waivers continued to play a significant role in the Medicaid program. As of May 2012, 34 states were operating at least one comprehensive Section 1115 Medicaid waiver.[6]

In addition, according to data from the Office of Management and Budget (OMB), federal funds flowing through Section 1115 waivers were to account for one-third of total federal Medicaid expenditures in 2012.[7]

Several states attempted to address, what they perceived to be problems with the health care industry, Oregon, Vermont, Maine, and Massachusetts were in the vanguard. However, the effort that would create the framework for the Affordable Care Act (ACA) was the one that was created in Massachusetts.

Negotiating the Reform

The Patient Assistance and Affordable Care Act (ACA), referred to by some as "Obamacare", was the subject of intense negotiations between the Obama administration, Congressional Democrats, and Congressional Republicans. The time was ripe for healthcare reform, the prior administration (that of George W. Bush) had enacted the Medicare Part D program to provide substantial prescription subsidies to certain portions of the population (primarily seniors) who were staggering under the cost of needed medications. (The cost of some prescription drugs is more complicated and controversial than can be addressed tersely here - let us say that many companies had their reasons for their pricing policies.)

Republicans came to the reform negotiation table offering some very valuable pieces (many now forget how many of the pieces of the ACA actually were not only supported but initially offered by Congressional Republicans). These elements are worth remembering as the now-majority Republicans reconsider healthcare, these elements included:

- Requiring coverage of pre-existing conditions.
- Offering a heath insurance tax credit for families under 200% of the Federal Poverty Level.
- Retaining younger adults on their parents coverage unto the age of 26.
- Enabling insurers to offer coverage across state-lines (expanding the coverage availability in many markets).
- Establishing tort reform bringing an end to frivolous lawsuits against providers reducing their cost to patients.
- Enabling associated coverage options, allowing small businesses and other entities to pool together and buy insurance as a group.

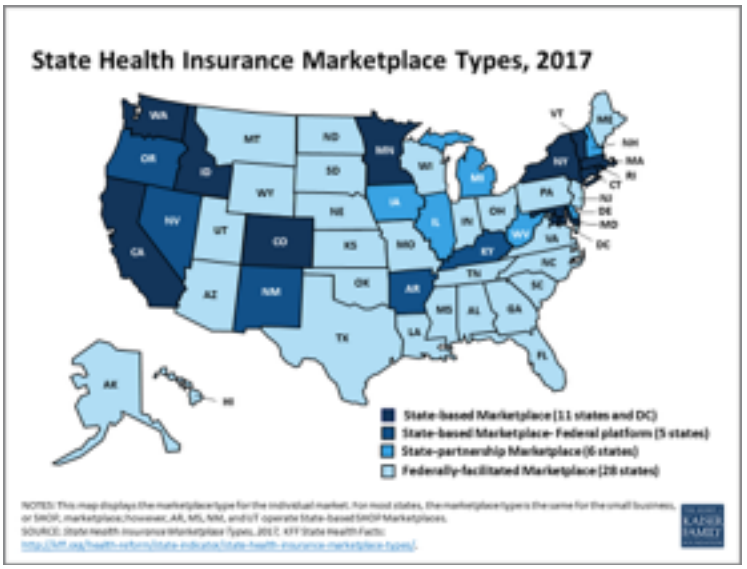
However, these options were not widely considered sufficient by the then-majority Congressional Democrats, who generally favored a single-payer (read federal-payer) health care option. They widely stated that the Republicans had no healthcare agenda, even though the minority party had proposed over 35 separate bills, and at least one inclusive plan in 2009.[8,9]

Provisions of the Affordable Care Act

On March 23, 2010, President Obama signed the Affordable Care Act into law. The ACA was highly controversial upon its passage (House Concurrence: 219-212 / 51%-49%; Senate: 60-39 / Party Line vote) and remains controversial today. The highlights of the Act included:

Individual Mandate: Requires all Americans to purchase health insurance (unless they qualify for an exemption), or pay a non-compliance penalty. This will be tracked and enforced by the Internal Revenue Service (IRS).

Healthcare Exchanges: Establishes "exchanges" at the state-level for individuals to purchase insurance if they are not covered through their employer, government, or union.



Guaranteed Issue: Prohibits health insurers from denying coverage based on current or prior health issues.

Minimum Coverage Standards: Policies must meet specified minimum coverage standards called essential health benefits (EHB).

Continued Coverage: Permits adult children to remain on their parent's coverage until age 26.

Medicaid Expansion: The Affordable Care Act (ACA) calls for states to expand Medicaid eligibility to an effective 138 percent of the poverty line for all non-elderly citizens and individuals who have lawfully resided in the United States for more than five years, are not age 65 or over, and are not eligible for Medicare. CBO estimates that as enacted, some 17 million more individuals, will enroll in Medicaid and the Children's Health Insurance Program (CHIP) by 2022.[9] The prior

level of coverage stood at 100% of the federal poverty level (unless augmented by individual states).

Reduced Provider Reimbursement*:*
An Urban Institute report has estimated a 42.8% reduction in Medicaid reimbursement rates for physicians as a result of the readjustments to pre-2013. The magnitude of the reduction depends on whether or not states have decided to extend the Medicaid primary fee bump using their own state funds. Due to ongoing budgetary concerns, many states were unable to use their own funds to extend the fee increase policy [3]. This has resulted in a variation of reimbursement rates across states. Alabama, Colorado, Iowa, Maryland, Mississippi, and New Mexico have elected to continue paying primary care services at the Medicare level. Conversely, Alaska, Connecticut, Delaware, Hawaii, Maine, Michigan, Nebraska, Nevada, and South Carolina are paying Medicaid fees at higher rates, but are not necessarily at the same level of Medicare rates. Consequently, many physicians which were near retirement age elected to leave practice, citing that their practices would no longer be profitable. This will lead to a new problem, at least in the short term, that of a shortage of doctors.[10]

Imposition of New Tax Provisions*:*
As of 2017, many Americans do not realize that the ACA contained a number of tax increases, this is primarily due to the fact that Congress has been delaying the implementation of some of these taxes. Cynics might argue that these delays were largely politically motivated; proponents would not want to enter an election cycle tarnishing what they believed to be a great achievement, while opponents would not want to impose taxes on the people if they were ultimately successful in repealing the Act. The taxes within the ACA include, a penalty for failing to prove insurance, a payroll tax hike, a tax on prescription medicine, and an IRS election to disallow tax deductions, among others. (The specific tax provisions of the Act will be addressed in a following section.)[11]

Legal Challenges
While there have been several lawsuits challenging the validity of the Affordable Care Act (ACA), there were three points of contention that bear special mention.

First. The individual mandate requirement. Many individuals objected to the fact that under the law government would be forcing its residents to purchase a product, that they might not otherwise purchase. This issue was addressed in *NFIB v Sibelius*,

Second. The mandate upon every state to set up a "Health Exchange", was viewed by many states as a violation of state's rights, and an unwilling drain upon state revenues which they did not believe sustainable. This issue was addressed in both *NFIB v. Sibelius* and *Oklahoma et al v Sibelius*, both found for the states. The courts found "it to be an excess of statutory jurisdiction, authority, or limitation". This finding led to the establishment of federal exchanges for state's unwilling to participate in this aspect of the ACA.

Third. Religious Freedom. Several entities found that the mandated coverage elements required of health insurers, violated both their religious freedom and common sense. For example, Catholic institutions could not see the purpose for them to pay for their priests and nuns to be covered for elements such as neonatal and maternity care. These were challenged in cases such as *Zubik v. Burwell* and *Catholic Diocese of DC v Burwell*. Resulting in only a partial victory for the plaintiffs, the court held "the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise", while still requiring them to make contraceptive coverage available.[12]

Agenda Concerns
The then-Democrat-led Congress that pushed forward the Patient Assistance and Affordable Care Act (ACA), over these and other objections. In the healthcare industry, many were of two-minds about the proposed ACA. Some viewed it as potentially beneficial leading to an increase in the number of individuals seeking care (thus improving market-share for some segments), and others who regarded it as beneficial for individuals who would be driven to seek healthcare before their situations became health crises. Others were concerned about some of the subtleties of the Act, and the track record of government-sponsored healthcare efforts in Canada and Europe.

Would the role of the Agency for Health Quality Research (AHRQ) be expanded to work in concert with CMS and lead to rationed care similar to Britain? This was of concern to health ethicists (who support the preeminence the doctor-patient relationship), and elements within the Biotechnology, Medical Device sectors (who, due to pending patents and cost-recovery models, had products that cost more than generic products they were designed to replace). In addition, few had any knowledge of the language contained in the ACA, and therefore were wary of what it might contain. For instance, it was rumored that there would be reduced provider reimbursement rates. Concerned providers were already suffering under the costs associated with filling out a seemingly growing amount of required insurance forms, and the need to maintain reimbursement in order to stay in business.

Among the people, there were still other concerns. For individuals, the individual mandate felt like government control over their personal freedoms, something to which many in this country are still fervently attached. This concern grew even more ominous when it was learned that the Internal Revenue Service, who had access to all of their personal financial information, would now have a

Lawsuits Challenging the ACA		
Case	**Topic**	**Finding**
NFIB v Sibelius (2012)	Individual Mandate	Stated affirmed the individual mandate's requirement to buy insurance (tax) was legal.
NFIB v Sibelius (2012)	State Exchange Requirement	Allowed states to opt-out of expanding Medicaid without losing current federal funding.
Priests for Life v. HHS (see also: Zubik v Burwelll Catholic Diocese of Wash DC v Burwell; East Texas Baptist Univ. v Burwell) (2015)	Religious Freedom Restoration Act; First Amendment	"Through this litigation, petitioners have made the Government aware of their view that they meet "the requirements for exemption from the contraceptive coverage requirement on religious grounds."
Pruitt v. Burwell (see also: Halbig v Burwell; Burwell v Hobby Lobby)	Mandated Coverage and Employer Coverage of Contraception	Petitioners must buy insurance since tax credits are available to individuals in States that have a Federal Exchange.
U.S. House of Representatives v Burwell (2014)	Violation of Executive Power (Appropriation)	Summary judgment to the House of Representatives and enter judgment in its favor.
Oklahoma et al. v Sibelius (2011)	Exchanges: sovereign states rights.	"The IRS Rule is … an abuse of discretion … not in accordance with law…, in excess of statutory jurisdiction, authority, or limitations, or short of statutory right, … is an invalid implementation of the ACA , "
Highmark; Blue Cross Blue Shield of North Carolina v Burrell (2016)	Failure of federal government to reimburse in a timely manner payments owed from the risk-corridor program.	None yet. (Uncertain outcome: ACA includes a clause allowing them three years to reimburse the private sector.)

pipeline to their medical information (one area that had previously been protected by a doctor-patient confidentiality and later by HIPPA).

For employers, there was also concern that providing medical insurance to their employees working more than 20 hours a week, could very well prove to be a cost too much to bear. Businesses were concerned about being able to afford this government mandate and preserving the businesses they had worked so hard to build over the years. Under the ACA, businesses with more than 50 employees are required to offer health coverage to all workers or be forced to make an Employer Shared Responsibility (ESR) payment based upon a set of variables (for illustration purposes, a rough approximate payment may total $2,000 per employee) after the first 30 uninsured employees.[13]

Then businesses were faced with still another slap in the face - that certain employers would not have to provide this coverage due to their status: this especially applied to unions. (Unions are supported by their members, not only are their large staffs well compensated, they also pay for employees to protest against the employers which would be mandated to cover the union workers in their businesses).

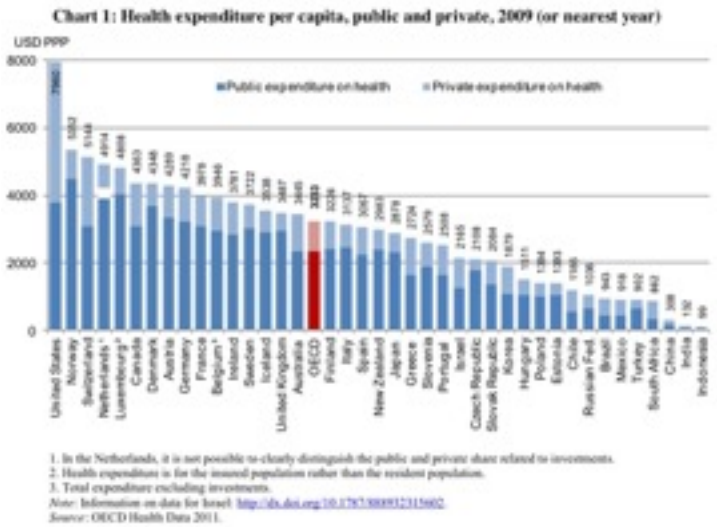
However, the exemptions would not be extended to religious institutions. Nor would they be able to purchase modified coverage appropriate for them, as a result the Catholic Church would have to pay for contraception insurance for its priests and nuns who had taken a vow of celibacy when entering service.

States would be required to pay for health insurance exchange options, even when they did not believe they could afford to maintain such an operation. State Exchange operations were considered very costly, and could have bankrupted many states. It was not until that requirement was challenged in court in *NFIB v Sibelius* that it was affirmed that the state's had the ability to opt out of the Exchange requirement.

[See table of "Lawsuits Challenging the ACA".]

Process Concerns

A large concern upon passage was the lack of time legislators had to digest the content and the impact of such a major piece of legislation. Further the quick vote seemed to deny the stakeholders, and the public from having any real sense of the content of the bill. Then majority leader Harry Reid (D-NV) scheduled the vote to close debate for 1am on Monday of Christmas week, providing Senators with less than 38 hours to understand a 383-page amendment that was to have a dramatic impact on all Americans and a major economic sector. Or, as one journalist put it, the ACA was "drafted behind closed doors and poised to be approved while Americans are not looking".[14]



Costs

Even prior to passage of the ACA, the United States government spent more per capita on health care than most countries with free, universal health care.[15]

At 17.4% of GDP in 2009, US health spending was half as much again as any other country, in the European OECD (Organisation for Economic Co-operation and Development) and nearly twice the average (9.6%).[16] Multinational firm PriceWaterhouseCooper reported that of the 30 million Americans who will be insured under the ACA, 45 percent will be signed up with individual exchanges and 23 percent will receive insurance through their employers. While the government will continue to fund Medicaid as it expands[16]

Between 2016 and 2026, the Congressional Budget Office estimates that the Affordable Care Act's insurance provisions will cost the federal government $136 billion more than expected, according to the latest report from the Congressional Budget Office.Mar 24, 2016.[17]

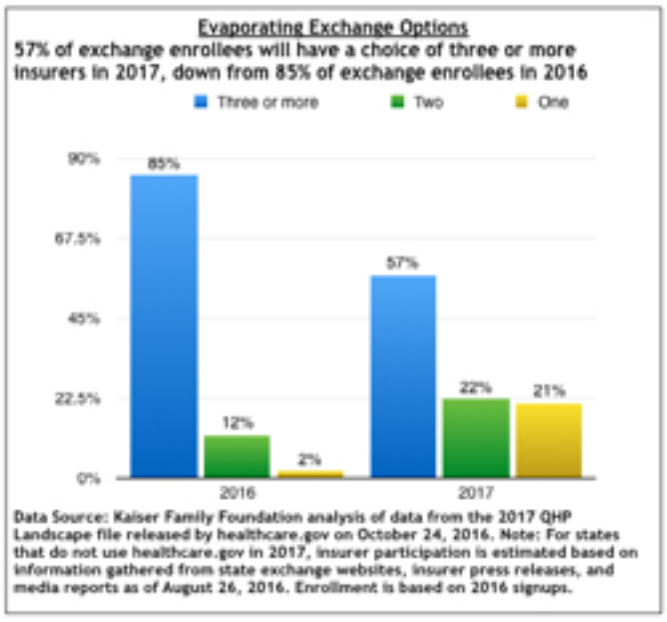
Between 2016 and 2025, the federal government will spend $1.34 trillion on the ACA's primary health coverage provisions. That mostly includes subsidies for the marketplaces and Medicaid expansion, and is partially offset by revenue-generating measures such as penalties tied to the individual and employer mandates. That total is up from the Congressional Budget Office's projection last March of $1.2 trillion. The is one factor underlining the difficulty for economists to predict the costs of a healthcare law that has evolved every year. The CBO also released updated figures on federal healthcare programs, showing that spending on Medicare, Medicaid, the ACA's exchanges and the Children's Health Insurance Program will total $15.56 trillion over the next decade,[18]

Sustainability

Health insurance companies, among others, are amplifying their warnings about the financial sustainability of the ACA exchange marketplaces as they seek approval for premium increases next year.

Some Insurers some have begun to talk about dropping out of the ACA created marketplaces altogether. they say they are losing money on their Exchange plans at a rapid rate. While some hopeful analysts believe the market will stabilize presuming insurers are granted the ability to raise premiums and more young, healthy people sign up, while other observers have not ruled out the possibility of a collapse of the market, known in insurance parlance as a "death spiral."

The Blue Cross Blue Shield Association released a widely publicized report in March of 2016, that said new enrollees under the ACA had 22 percent higher medical costs than people who received coverage from employers. And a report from McKinsey & Company found that in the individual market, which includes the



Exchange marketplaces, insurers lost money in 41 states in 2014, and were only profitable in 9 states.[19]

In August 2016, Aetna announced that it would be dropping around 80% of their policies offered through the ACA's public-health exchanges after sustaining large losses on the ACA business model. This made Aetna the third of the "big five" insurance firms (which includes Humana, United Health Care, Cigna, and Anthem) to announce a serious cut to their ACA business. The firm will be out of nearly all of the exchanges by 2017.

In addition to the Aetna news, the New York Federal Reserve issued a study that showed one out of every five businesses in the bank's district — which includes parts of New Jersey and Connecticut — said they were reducing hiring due to the Affordable Care Act. [20]

New Taxes for Program Implementation

Congress found it necessary to impose new taxes on Americans to generate the anticipated revenues to pay for this new program. Some of these taxes have been forestalled by Congressional delaying actions and have not yet gone into effect. In addition to the most publicized penalty, that for failure to obtain insurance (as described below), these taxes include:

Mandate failure Penalty: Individuals who fail to obtain health insurance must pay an income surtax to the IRS. In 2014, close to 7.5 million households paid this tax. Most make less than $250,000. Regulators use the phrase “shared responsibility payment” to describe this tax. For tax year 2016, the tax was a minimum of $695 for individuals, while families of four have to pay a minimum of $2,085.

“Medicine Cabinet” Tax on HSAs and FSAs: 20.2 million Americans with a Health Savings Account (HSA) and the 30 - 35 million covered by a Flexible Spending Account (FSA) are no longer able to purchase over-the-counter medicines using these funds (Examples include cold, cough, and flu medicine, allergy medicines, and dozens of other common medications).

Flexible Spending Account Tax: The 30 - 35 million Americans who use a pre-tax Flexible Spending Account (FSA) at work to pay for their family’s basic medical needs face a cap of $2,500 - costing Americans $32 billion over ten years. Special needs children’s tuition payments under this account would be terminated.

Chronic Care Tax: directly targets middle class Americans with high medical bills. The tax hits 10 million households every year. Raising the threshold for households before they are allowed a tax credit for expenses that from 7.5% to 10% of the AGI. This is anticipated to cost taxpayers $40 billion over the next ten years.

HSA Withdrawal Tax Hike: increases the tax on non-medical early withdrawals from an HSA from 10 to 20 percent, disadvantaging them relative to IRAs and other tax-advantaged accounts, which remain at 10 percent.

Ten Percent Excise Tax on Indoor Tanning: The Obamacare 10 percent tanning tax has wiped out an estimated 10,000 tanning salons, many owned by women. This $800 million Obamacare tax increase was the first to go into effect (July 2010). This petty, burdensome, nanny-state tax affects both the business owner and the end user. Industry estimates show that 30 million Americans visit an indoor tanning facility in a given year, and over 50 percent of salon owners are women. There is no exception granted for those making less than $250,000 meaning it is yet another tax that violates Obama’s “firm pledge” not to raise “any form” of tax on Americans making less than this amount.

“Cadillac Tax” -- Excise Tax on Comprehensive Health Insurance Plans: In 2020, a new 40 percent excise tax on employer provided health insurance plans is scheduled to kick in, on plans exceeding $10,200 for individuals and $27,500 for families. According to research by the Kaiser Family Foundation, the Cadillac tax will hit 26 percent of employer provided plans by 2020 and 42 percent of employer provided plans by 2028. Over time, this will decrease care and increase costs for millions of American families across the country.

Health Insurance Tax: In addition to purchase mandate, ACA imposes an increase to the cost of insurance through the health insurance tax. According to the American Action Forum, the ACA health insurance tax will increase premiums by up to $5,000 over a decade. It will directly impact 1.7 million small businesses, 11 million households that purchase through the individual insurance market and 23 million households covered through their jobs. The tax is projected to cost taxpayers – including those in the middle class – $130 billion over the next decade. In addition, the National Federation for Independent Businesses (NFIB) estimates the tax could cost up to 286,000 in new jobs and cost small businesses $33 billion in lost sales by 2023. While it is directly imposed on industry, the costs are inevitably passed on to small businesses that provide healthcare to their employees, middle class families through higher premiums, seniors who purchase Medicare advantage coverage, and the poor who rely on Medicaid managed care.

Employer Mandate Tax: Forces employers to pay an estimated $2,000 tax per full time employee if they do not offer “qualifying” – as defined by the government -- health coverage, and at least one employee qualifies for a health tax credit. According to the Congressional Budget Office, the Employer Mandate Tax raises taxes on businesses by $166.9 billion over the ten years.

Investment Income Surtax: A new, 3.8% surtax on investment income earned on individuals making $200,000 (or couples making more than $250,000), creates a new top capital gains tax rate of 23.8%. Will increase taxes by $222.8 billion over ten years.

Payroll Tax Hike: Adds an additional 0.9% payroll tax on individuals making $200,000 (or couples making more than $250,000). This will increase tax liability on Americans by $123 billion over ten years.

Tax on Medical Device Manufacturers: Imposes a new 2.3% excise tax on all sales of medical devices. This applies even if the company has no profits in a given year. The tax was recently paused for tax years 2016 and 2017. It will cost Americans $20 billion by 2025.

Tax on Prescription Medicine: A new tax on the producers of prescription medicine based on relative share of sales. This is a $29.6 billion tax hike over the next ten years.

"Economic Substance Doctrine" (codified): Allows the IRS to disallow otherwise legal tax deductions and other legal tax-minimizing plans, if the IRS deems it is intended to reduce taxes owed (which is an argument they could claim for any legal deduction). Over ten years, this will cost taxpayers an estimated $5.8 billion.

Eliminates Deduction for Retiree Prescription Drug Coverage: The elimination of this deduction is a $1.8 billion tax hike over ten years.

Executive Health Insurance: Places a $500,000 Annual Executive Compensation Limit for Health Insurance Executives: This deduction limitation is a $600 million tax hike over ten years.[21]

Decrease in the Uninsured

Despite the substantial projected increases in insurance coverage under the ACA, CBO and JCT estimate that in 2024, 31 million people, or roughly one in nine non-elderly U.S. residents. Before passage of the ACA, 57 million were estimated without coverage.

Conclusion

The spiraling costs of healthcare in this country, made legislative action inevitable. The question from the beginning of the discussion was always, how deeply did Congress need to disrupt the private marketplace. One of the reasons the Affordable Care Act was modeled after the Massachusetts plan, was that MassCare appeared least disruptive to the private marketplace. However, the passage and implementation of the Affordable Care Act, is likely to foster political discourse for years to come.

The mandates, and taxes, are the most obvious lightening rods in this legislation. Whether it is the requirement for individual taxpayers to purchase a healthcare plan, or face penalty imposed by the Internal Revenue Service. The mandated healthcare insurance requirements that will make individuals, employers, and insurers offer coverage elements that are not needed by those parties; The mandate upon the individual states that they form an insurance exchange program, has been dealt with in the courts (permitting the states to opt out). However, other elements of the Act also drew their fair share of criticism, including the reduction of reimbursement to providers, which led many providers to conclude it was no longer profitable to see public payer patients.

While there are elements within the ACA which have strong bi-partisan support, many oppose the overall construct of the Act. Among the broadly supportable elements were those to require coverage of pre-existing conditions, and permitting younger adults to remain on their parents coverage unto the age of 26. The inclusion of these elements within the overall scope of the Act are not enough to save it from criticism on other fronts.

Criticism of the Act was to be expected, no matter what shape reform would have taken - there are individuals who have strong ideas about how the market should work, and the flexibility that should be allowed among plans. Like most significant political arguments in recent years, the extremes tend to dominate the media and hence the public perception of the issues. The reality is found on the middle ground. Proponents of universal health care, and fervent supporters of the Affordable Care Act, will rail against any changes as disastrous to health care delivery. Meanwhile there are opponents of health care reform that may well rail against any element that was included in the original legislation. Any amendment or reform of the Act will open the door to a much broader discussion.

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