The Affordable Care Act: triumphs and tribulations

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Abstract

Purpose – This paper aims to discuss key provisions of the Affordable Care Act (ACA) and the obstacles faced by the federal government in achieving its goal. The ACA is designed to provide most Americans with access to affordable health care.

Design/methodology/approach – Using data obtained from government sources, case law and current literature, the paper first discusses the history and background of the ACA. It evaluates the law’s current status, the benefits it achieved and the legal, economic, political and social challenges that lie ahead.

Findings – Although the Supreme Court upheld most of the ACA’s provisions, opponents at the federal and state level are still attempting to overturn or undercut it. The ACA itself is so complicated that it has generated confusion among employers, consumers and even those who are charged with enforcing it. The extent to which the ACA can be successfully implemented is unclear, and adjustments must be made as the federal government struggles to implement key components.

Originality/value – This paper should be of interest to academics, health-care and legal professionals, and to anyone who needs clarification and analysis of a still-evolving law that is certain to have an impact on most Americans.

Keywords Health-care reform, Affordable Care Act, Health insurance

Paper type Research paper

History and background

The USA has the most expensive health-care system in the world, yet our health outcomes do not compare favorably with other Western nations (Davis et al., 2013). In 2010, per capita health costs in the USA were $8233, as compared with the next highest per capita cost of $5388, in Norway (OECD Health Data, 2012). US spending per capita was more than double that of most other Western nations, including France, Sweden, Australia and the UK (OECD Health Data, 2012). The USA has lower average life expectancies and higher infant mortality rates than many industrial nations, and it is the only Western industrialized nation that does not provide universal health coverage to its citizens (Fisher, 2010). In 2010, there were approximately 50 million people in the country without health insurance[1].

After a decades-long struggle to reform the health-care system, Congress narrowly passed the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA is a lengthy and complex document, with provisions that phase in over several years. Starting in 2010, consumers received protection from a variety of abuses by the insurance industry, and access to care was expanded for many Americans. For example, children under the age of 19 years could no longer be denied coverage due to pre-existing conditions, lifetime dollar limits on insurance coverage for essential benefits were
eliminated, and insurance companies were no longer permitted to rescind coverage due to innocent errors or technical mistakes. Cost-free preventive services were provided to many consumers, and young adults were permitted to remain on their parents’ policies until the age of 26[2]. Additional provisions designed to expand access and enhance quality of care while controlling costs were phased in between 2011 and 2013. The biggest changes are scheduled to take effect in 2014, with the goal of providing almost every American with access to affordable health care.

In 2014, insurance companies will be prohibited from discriminating due to an individual’s health status, pre-existing conditions or gender[2]. To pay for this, most US citizens and legal residents are required to have qualifying health insurance coverage beginning in 2014, or else must pay a tax penalty which varies according to income. This critical provision of the ACA is commonly referred to as “the individual mandate”.

The ACA contains a number of provisions to enable most individuals to obtain affordable insurance. The ACA originally scheduled a January 1, 2014 effective date wherein most employers will be required to offer coverage to their employees or pay a penalty. For example, employers with more than 200 employees are required to automatically enroll them in qualified health insurance plans. Employees can opt out of coverage if they so choose. Employers with 50 or more full-time employees must offer appropriate insurance coverage or pay a penalty of $2000 per employee if at least one full-time employee receives a federal premium subsidy for exchange coverage (the “Employer Mandate”)[3]. For reasons discussed below, the employer mandate was delayed until 2015. The ACA preserves the private marketplace, and also creates new, virtual marketplaces to enable small businesses as well as individuals who cannot get insurance through their employers to shop for health insurance. Exchanges are designed to help consumers and small businesses shop for coverage by providing easy comparison of plan prices, benefits, services and quality[4], and it is estimated that they will serve over 20 million Americans within the next few years. Individuals who purchase insurance through an Exchange will be eligible for subsidies and cost-sharing if their income is less than 400 per cent of the federal poverty level. Tax credits are also available for eligible small businesses that choose to provide insurance for their employees. The ACA also provides for expanded Medicaid eligibility to provide access to health care for millions of low-income individuals, with financial support from the federal government. However, implementing the ACA is proving much more difficult than anticipated.

The Supreme Court challenge

The ACA was controversial from the outset. Immediately after it was signed into law opponents mounted court challenges:

Within a year of the Act’s promulgation, 28 states had joined in or filed separate suits challenging the ACA, and five courts had reached decisions on the merits (Dolgin and Dietrich, 2011).

While a number of issues were raised, the lower courts focused on the argument that the individual mandate exceeded the power granted to Congress under the Commerce Clause (Dolgin and Dietrich, 2011, p. 59). Challenges to the constitutionality of the ACA were heard by the US Supreme Court, in National Federation of Independent Business v. Sebelius (NFIB), in March 2012 (National Federation of Independent Business v.
In June 2012, the Supreme Court upheld most provisions of the ACA by the narrowest of margins. The Court upheld the individual mandate – the central and most controversial provision – finding that while Congress exceeded its authority under the Commerce Clause, the penalties under the ACA could properly be construed as a “tax”, and thus fell within Congress’s constitutional taxation powers (National Federation of Independent Business v. Sebelius, 2012, p. 26078) However, the Court struck down a portion of the Act, limiting the ability of the federal government to expand access to health care for low income Americans. The ACA had required States to expand their Medicaid programs by 2014 to cover everyone under the age of 65 with incomes below 133 per cent of the federal poverty line. §1396a(a)(10)(A)(i)(VIII). The Act also provided that States were required to provide “essential health benefits” to all new Medicaid recipients at a level sufficient to satisfy a recipient’s obligations under the individual mandate. §§1396a(k)(1), 1396u–7(b)(5), 18,022(b). Any state that did not comply with the Act’s new expanded coverage requirements would lose all of its federal Medicaid funds. See Section 1396c. (National Federation of Independent Business v. Sebelius, 2012, p. 26078) The Supreme Court held that the ACA’s expansion of Medicaid eligibility exceeded Congress’s Authority under the Spending Clause, because the federal government may not “compel the States to enact or administer a federal regulatory program” (National Federation of Independent Business v. Sebelius, 2012, p. 2598; New York v. United States, 1992). The Supreme Court found that the ACA improperly:

 [...] transformed Medicaid into a program to meet the health-care needs of the entire nonelderly population with income below 133 per cent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage (National Federation of Independent Business v. Sebelius, 2012, p. 2606).

While the ACA can permissibly offer federal funds to encourage states to expand their Medicaid programs and administer them in accordance with ACA requirements, it is unconstitutional to penalize states that choose not to participate in the Medicaid expansion by taking away their existing Medicaid funding (National Federation of Independent Business v. Sebelius, 2012, p. 2602). Expanded access to Medicaid is now in the hands of each state. Many states rejected the Medicaid expansion[5]. Millions of Americans in those states will either lose access to care or will be required to obtain insurance through one of the health insurance exchanges provided for under the ACA. States rejecting Medicaid expansion have also refused to create state-run insurance exchanges, so the task of reaching out to this vulnerable population and enrolling them will fall to the already overburdened federal government.

Legal challenges to the ACA after NFIB

Legislative efforts

The Supreme Court’s decision in NFIB was among the most eagerly anticipated decisions in US history. Although the Court’s decision has been hailed as a landmark ruling and a victory for proponents of the ACA, the fate of health-care reform is far from settled. Legislative efforts to repeal, limit or refuse to enforce the ACA have continued despite the Court’s ruling. The US House of Representatives, along party lines, made 37 failed attempts to repeal all or part of the ACA (Fahrenthold, 2013). Unable to repeal the law outright, the House repeatedly blocked funding needed to implement the law,
including outreach to encourage consumers to enroll in the insurance marketplaces that are essential to the success of the ACA (Kaiser Health News, 2013). As a result of the rejected funding requests, Health and Human Services Secretary Kathleen Sibelius sought donations and other assistance from health industry executives, community organizations and others in the private sector to help raise awareness of the law and enroll the uninsured.

At the state level, the National Conference of State Legislatures reports that as of April 23, 2013, there were bills in at least 29 different states, territories or DC relating to challenges, opposition or alternatives to health reform. They include formal rejections of Medicaid expansion and prohibitions on running state-based exchanges, but they do not include challenges to measures such as mandated coverage of contraception. The individual and employer coverage mandates have been a primary focus of state opposition, and many states have statutory or state constitutional language providing that state government will not implement or enforce mandates requiring the purchase of insurance by individuals or payments by employers. Although the Supreme Court upheld the individual coverage mandate, it does not require a state role. States cannot prevent the federal government from enforcing the ACA, but they can choose to prohibit state enforcement[6]. States’ resistance to the ACA will be a significant barrier to successful implementation.

**Litigation**

Not only did NFIB fail to halt court challenges to the ACA, the characterization of the individual and employer mandates as “taxes” actually raised new issues for litigation. There are several constitutional challenges that, if successful, might deal a crippling blow to the ACA. The most ambitious, Liberty University v. Geithner, (Liberty University v. Geithner, 2012; Liberty University v. Jacob Lew, 2013) raises a number of constitutional issues, including challenges to the ACA employer mandate.

In September 2011 the 4th Circuit Court of Appeals dismissed the case, and the US Supreme Court denied certiorari on June 29, 2012. However, in November 2012, Plaintiffs’ Petition for Rehearing with the US Supreme Court was granted, vacating the previous denial and remanding the case back to the 4th Circuit to consider the challenges to the ACA in light of the Court’s holding in NFIB. At the time of this writing, the case is pending the decision of the 4th Circuit Court of Appeals.

Liberty University challenges the employer mandate on several grounds, including a lack of Congressional authority under the Commerce Clause, as well as challenges to the characterization of the employer mandate as a “tax”. It argues that while the Supreme Court upheld the individual mandate as a valid exercise of Congress’ authority under the Taxing and Spending Clause in NFIB, the employer mandate exceeded that authority:

Applying NFIB’s analysis of Bailey v. Drexel Furniture Co., 259 USA 20, 36-37 (1922) to the employer mandate establishes that it is an impermissible penalty. See NFIB, 132 S.Ct. at 2595-2596. In Drexel Furniture, the Supreme Court focused upon three characteristics of the challenged exaction to conclude that it was an impermissible penalty – i.e. it imposed an exceedingly heavy burden regardless of the de minimis nature of the offense […]. The employer mandate, unlike the individual mandate does impose a heavy burden on employers […]. If Liberty University does not provide insurance coverage, it will be fined $2000 per employee per year, resulting in millions of dollars of penalties […] (Liberty University v. Jacob Lew, 2013).
Liberty further argues that as a non-profit organization, it is tax-exempt, and the employer mandate “cannot be upheld as a permissible tax as applied to non-profit organizations”, and in any event, the tax is improper because it did not originate in the House, thus violating the Origination Clause.

Another type of challenge which, if successful, would threaten the effective implementation of the ACA is the argument that the Internal Revenue Service (IRS) lacks the authority to allow tax credits to subsidize individuals who purchase insurance through federally run health insurance exchanges. The ACA provides that people who earn up to 400 per cent of the federal poverty level are eligible to apply for tax credits to help offset the cost of insurance purchased through the exchanges. The Act’s language refers to “state-run” exchanges, as it was originally envisioned that most, if not all states, would set up and run their own exchanges. However, that did not occur. Most states will either have exchanges that are either partially or completely run by the federal government. Recognizing this problem, the IRS issued a regulation in May 2013 that would provide for credits regardless of whether the exchange was run by the state or federal government. In Pruitt v. Sebelius Attorney General of Oklahoma argues that the IRS is, in effect, was re-writing the ACA without the constitutional authority to do so. The IRS claims that the regulation is consistent with the language and intent of the Act. A successful challenge on this issue would mean that in states which chose a federal insurance exchange, the employer mandate would be avoided, as the mandate only applies to employers that have at least one subsidized employee.

The most common constitutional challenge to the ACA deals with the Health and Human Services’ requirement that employer-provided group insurance plans cover all forms of US Food and Drug Administration (FDA)-approved contraception as part of “essential health benefits” that insurance companies must provide without cost-sharing. The requirement is designed to ensure the coverage of preventive-care services, including birth control. Approximately 60 lawsuits have been filed in various courts on religious grounds, with allegations that employers would be forced to pay for services contrary to their religious convictions, in violation of the Religious Freedom Restoration Act of 1993 and/or the First Amendment (Jost, 2013a). While the contraception cases do not threaten the existence of the ACA, they have an important impact on patient benefits, and they raise important legal and ethical questions:

Can for-profit employers have religious beliefs? Do corporations hold the religious beliefs of their owners? Should the religious beliefs of employers determine employees’ access to medical care? Are the religious beliefs of religious organizations violated if they do not have to pay for contraceptives but their employees are insured for them anyway? Does the government have a compelling interest in requiring insurers and employers to cover contraceptives? Would there be a way of providing these services that is less restrictive of religious beliefs? (Jost, 2013a).

Courts have had varied responses to these issues, and they will most likely be heard by the US Supreme Court at some point.

Moving forward: ACA triumphs and tribulations
Assuming that the ACA remains substantially unscathed despite efforts to destroy it via litigation or legislation, significant additional provisions will take effect in the coming year. However, the complexity of the Act itself along with continued resistance
to its implementation will almost certainly limit its effectiveness. There is considerable uncertainty regarding the degree to which the ACA will increase the access and how much it will cost. The Act has already produced significant benefits, and despite staggering obstacles, there will hopefully be more to come.

Since the ACA’s enactment in 2010, access to affordable care has been expanded. Millions of Americans currently benefit from a variety of provisions, for example:

- Insurers are now covering a number of preventive services, such as cancer, diabetes and blood pressure screenings, without additional cost sharing such as copays or deductibles.
- Seniors are receiving discounts on prescription drugs that formerly fell into the “donut hole” gap in Medicare coverage, with additional savings to be phased in each year until the coverage gap is closed in 2020.
- Over 3 million young adults now have health insurance through their parent’s plan.
- Approximately 12.8 million consumers received $1.1 billion in rebates from insurance companies that failed to spend at least 80 per cent of their premium dollars on health care.[7]
- The number of uninsured adults and children declined (Holihan and McGrath, 2013).

The goal of providing access to affordable health insurance to millions of more Americans is to be achieved in the coming years through expanded Medicaid coverage and opportunities for employers and individuals to obtain coverage via state-based insurance exchanges. By all accounts, the path to implementation will be difficult. The federal government will be required to coordinate and implement much of the Act in the face of continued opposition, and the Act itself is complex. There is widespread confusion at the state and federal level among consumers, the business community and in an administration scrambling to meet deadlines.

**Medicaid expansion**

As of June, 2013, approximately 30 states agreed to accept Medicaid expansion by the ACA’s effective date of January 1, 2014, and several of those states had already adopted it ahead of schedule[8]. Pressure is mounting on states to accept the expansion and the federal funds that go with it. The federal government will pay the entire cost of the expansion for the first three years, with reduced funding each year until it reaches 90 per cent in 2020 and thereafter. Business organizations and other advocacy groups are urging their states to accept the federal Medicaid plan, claiming that it will save money. For example, in New Hampshire, a number of businesses, health-care organizations and other advocacy groups got together to urge senators to accept Medicaid expansion. It was argued that delaying the expansion would cost New Hampshire $350 million next fiscal year – money the state could never get back (Rano, 2013). Expansion was estimated to cost between $27 million and $85 million over the next seven years, while bringing in an estimated $2.5 billion during that time. Moreover, it is expected to add 58,000 New Hampshire residents to the program. Nevertheless, the number of states rejecting the expansion is substantial[9]. The ACA will probably fall well short of its
goals as a result, but in participating states, millions of low-income individuals will have access to coverage previously unavailable.

**Health insurance exchanges**

One of the key provisions of the ACA is the creation of health insurance exchanges. The operation of these exchanges is critical to the Act’s success, and many aspects of their implementation are uncertain:

States are currently responsible for regulating most health insurance, and state insurance markets vary greatly due to different legal requirements as well as differences in demographics and geography. Because of these differences, the ACA intended the exchanges to be state run: The law gives states first crack at designing and implementing the exchanges within its broad requirements and offers funding to help states with these efforts (Calsyn, 2012).

Enrollment in the exchanges is scheduled to begin October 1, 2013, for the January 1, 2014, start of coverage. States can choose to develop a fully state-based exchange, or they can enter into a state–federal partnership exchange, taking day-to-day responsibility of plan management and customer assistance in a federally facilitated exchange. The ACA provides that any state that fails to develop and implement an exchange will default into a federally facilitated exchange (FFE), to be established and operated by Health and Human Services. In June 2013, the US Government Accountability Office (GAO) reported that the federal government was unprepared for the beginning of the October enrollment period for the health exchanges, and it could not be determined whether they would be ready in time[10]. Critical tasks such as final testing with federal and state partners, certification of Qualified Health Plans (QHP) and inclusion of QHP information on the exchange Web sites were not completed. In the case of consumer assistance, funding awards for Navigators – a key consumer assistance program designed to educate the public about QHPs – was delayed by about two months, which then delayed training and other activities. The Centers for Medicare and Medicaid Services (CMS) was also depending on the states to implement specific FFE exchange functions, and CMS data revealed that many state activities were behind schedule[10]. Moreover, the GAO report indicates that CMS’s required activities in each state are “still evolving” and were not clearly defined. Critics seized on the report as evidence of a system in chaos. In fact, the situation is probably even worse than the report indicates, as the GAO’s information was derived from federal government sources. There was no effort to interview or collect information directly from the states, many of which would be more likely to characterize the status of the health exchanges in much harsher terms. This is particularly troubling, as state cooperation is needed for successful implementation. Close federal–state coordination is required to accommodate each state’s existing health insurance market and health-care needs (Calsyn, 2012, p. 2). The political environment may make this extremely difficult. The ability to purchase competitively priced insurance policies through the exchanges will therefore vary significantly from state to state.

Insurance premiums are a wild card. The reports of increased price competition are contradicted by evidence that rates are set to increase dramatically for many consumers. Predictions of rate increases vary widely, even among those analyzing rates within the same state, and they seem to depend more on the analyst than on objective data. For example, in California, one of the earliest states to develop its...
own health insurance exchange, state exchange officials estimated that rates would be “from 2 per cent above to 29 per cent below the 2013 average premium for small employer plans” (Humer and Beasley, 2013). The projections were quickly disputed, with estimates that prices were in fact going up as much as 146 per cent for some Californians. In other states, such as Washington, Oregon and Vermont, Republican outcries about “Obamacare rate shock” were somewhat reduced when low proposed premium rates were released (Humer and Beasley, 2013). Although there are serious challenges to overcome, some progress can be seen in states that are embracing the health insurance exchanges. There is evidence of increased competition, with many new insurers entering the market. Existing providers are also competing aggressively, designing more affordable and innovative plans. The majority of states will have insurers that offer plans across state lines:

The new law places strict limits on how much of every dollar of premium can go to anything other than medical expenses, and the insurers say success will depend on enrolling as many customers as possible rather than figuring out how high a premium they can charge to raise profits (Abelson, 2013).

It is generally acknowledged that it will take several years for the health insurance exchanges to take shape, and the average cost of premiums over the next few years cannot be easily predicted.

It is important to note that even if there is an abundance of insurance options available, the success of the ACA depends on enrolling large numbers of Americans, particularly those who are young and healthy. This group is needed to offset the cost of insuring those who are sicker and utilize more care. It is uncertain whether that enrollment goal will be met. This group often sees itself as “invincible” and they may decide that it is preferable to pay the relatively small penalty instead of purchasing insurance. Lack of accurate information and premium costs are significant barriers. The federal government, advocacy groups and other public and private stakeholders will need to continue their involvement in education and outreach to encourage enrollment.

Enrollment success rates may also be impacted by the one-year delay in enforcing the employer mandate, which will now take effect on January 1, 2015 due to the complexity of the law and the burdensome reporting requirements. The administration is considering making adjustments to the reporting requirements, and it is also hoping that the additional time will enable more effective implementation by the business community. While most large employers already offer insurance to their employees and will probably continue to do so, the delay raises concerns about the impact on health-care access as well as the economy. The lack of an employer mandate may mean that many employers will not expand, or may even drop coverage in 2014. As a result, more individuals “may end up on CHIP or Medicaid or become eligible for tax credits” (Jost, 2013b). In addition, individuals who do not have the access to affordable insurance from their employers may not purchase insurance elsewhere. The economic impact may be considerable: “The CBO has projected most recently that the employer penalty would yield $10 billion in 2015, presumably from employers who fail to provide coverage in 2014” (Jost, 2013). Questions have also arisen regarding the impact on the individual mandate:
How will it be enforced in the absence of employer reporting for 2014? Will the individual mandate’s enforcement also be delayed?

Conclusion
As the ACA enters its most critical phase, even its most ardent supporters acknowledge that the federal government faces serious legal, political, practical and financial constraints, as it attempts to expand Americans’ access to affordable health care. Despite the Supreme Court’s validation, the ACA still faces legislative and court challenges that threaten its implementation, and even its very existence. Assuming that the ACA remains substantially intact, success is by no means certain. The sweeping changes soon to take effect are confusing to businesses, individuals and even to those charged with enforcing it. It is unclear whether the large numbers of Americans soon to be eligible for insurance will actually enroll in the new plans, nor is it certain that the health insurance exchanges will be ready when the enrollment period begins. Cost is a significant barrier, and premiums may be prohibitive, even with government subsidies. Moreover, a large percentage of the public still opposes the ACA. The delay in enforcing the employer mandate reinforces their belief that the Act, the product of a disorganized administration, has gone badly off track. Clearly, critics will find it easy to identify many ways that the ACA falls short in the coming years.

It would wrong, however, to lose sight of the existing benefits of the ACA and its potential to improve our health-care system going forward. Our health-care system is significantly more expensive and generally less effective than any of our Western industrial counterparts. The ACA is a major departure from the unsustainable path we have traveled for decades. While the road ahead is rocky and detours are inevitable, the ACA is an important step forward.

Notes


References


Liberty University v. Geithner [2012], 133 S.Ct. 679, granting petition for remand to the Court of Appeals for the 4th Circuit; 671 F.3d 391 (4th Cir. 2011).
Liberty University v. Jacob Lew, [2013], Supplemental Reply Brief on Remand of Appellants Liberty University, et. al., Filed 04/24/2013; Appeal: 10:2347, Doc: 190, at pp. 8-10.


New York v. United States [1992], 505 US, 144, 188.


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