The Affordable Care Act, One Year Later

By Michael J. Velezis

More than four years after the Affordable Care Act's (ACA)[1] passage, two years after the United States Supreme Court upheld its constitutionality[2] and one year following initial open enrollment, the spirited debate on the ACA continues.[3] After all that time, it is still too early to understand fully the ACA's long-term impact on the delivery and payment of American healthcare. It will take more time to receive the statistically meaningful data necessary to determine the ACA's lasting effects on healthcare costs, uninsured levels and healthcare providers' ability to service the increased demand for care.

This article addresses the more immediate effects on healthcare of the ACA and its implementation, utilizing the ACA's objectives of increased affordability and access to healthcare to guide the discussion, while addressing employer reactions and Alabama specific impacts.

Premium Impact and Accessibility

The ACA reduced health plan premiums for some individuals and families, and increased premiums for others. The ACA's impact on premiums varies based on several factors, including:

- Preclusion of waiting periods and health underwriting for pre-existing medical conditions. Consumers now have access to healthcare coverage regardless of their health conditions, and premiums cannot vary based on an individual's health status.
- Premiums under the ACA are determined by the metallic plan you choose–bronze, silver, gold or platinum–county of residence, the number and ages of your family members and whether they use tobacco.
- The ACA requires member-level rating. Pre-ACA, Blue Cross® and Blue Shield® of Alabama[4] offered one single premium and one family premium no matter the number of family members. The ACA now requires that each family member on a policy be rated based on age, address and tobacco use. These individual rates are then added together to calculate the family's premium. As a result, larger families may experience higher premiums.
- The ACA limits how much insurers can vary premiums based on an individual's age to a ratio of 3:1, down from a typical pre-ACA ratio of 5:1. This means that the premium rates for older adults cannot exceed more than three times the rate of a younger person.
- The ACA requires the inclusion of additional benefits. Nationally, less than two percent of pre-ACA plans covered all of the ACA's 10 essential health benefits.[5]

- The ACA's medical loss ratio rule (MLR) requires health insurers to spend at least 80 percent (individual and small employer health plans) or 85 percent (large employer health plans) of premium dollars on patient care and initiatives to improve quality of care, or refund the difference to customers.
- Provision of premium cost subsidies under the ACA for those who qualify
- The ACA also imposes a number of new fees and taxes.

A. Premium subsidies and affordability

The ACA's subsidies, in the form of tax credits, significantly offset 2014 health plan premium costs for some Alabama consumers and families. Upon the conclusion of the ACA's first open enrollment period, around 97,870 Alabama residents enrolled in health insurance marketplace plans. About 85 percent of those consumers received financial assistance.[6] To be eligible to receive premium tax credits in 2014, an individual's annual income had to be less than $46,680 and a family of four's annual income less than $95,400.

The Alabama residents who received 2014 tax credits had a premium that averaged 77 percent less than the full premium.[7] Tax credits reduced their premiums, on average, from $334 to $76 per month[8]–the eighth-lowest premium cost of the 36 Federally Facilitated Marketplace (FFM)[9] states, which include Alabama. After the application of tax credits, 73 percent of Alabama exchange consumers had premiums of $100 or less, while 53 percent had premiums of $50 or less.[10] Alternatively, unsubsidized health plan premiums were found to have increased nationally from 2013 to 2014 for all age groups studied.[11] Younger men received a 78.2 percent premium increase, the largest among the groups analyzed, while older men experienced the smallest increase, 22.7 percent.[12]

Whether subsidies will continue to reduce premiums in the future for FFM plan holders is currently in question. On July 22, 2014, in *Halbig v. Burwell*,[13] a three-judge panel of the United States Court of Appeals for the District of Columbia Circuit ruled that the ACA, by its terms, limits subsidy offerings to "state-run exchanges," not those run by the federal government. At the time of this article's writing, this 2-1 ruling is on appeal by the government to the full court, with argument scheduled in December 2014.

Contradicting the *Halbig* court's ruling just two hours later, a second three-judge panel of the United States Court of Appeals for the Fourth Circuit, in *King v. Burwell*,[14] unanimously ruled that consumers may receive subsidies from the Federally Facilitated Marketplace. Plaintiffs decided not to appeal *en banc* to the Fourth Circuit but instead appealed directly to the United States Supreme Court. On September 30, 2014, in a third subsidy challenge case, *Pruitt v. Burwell*,[15] the United States District Court for the Eastern District of Oklahoma sided with *Halbig* and ruled that providing tax credit subsidies to FFM plan recipients goes beyond the ACA's authority. Finally, the United States District Court for the Southern District of Indiana, in *Indiana v. IRS*,[16] has a similar subsidy challenge pending.

As these divergent rulings work through the legal system, they may contribute to a circuit split that may make the Supreme Court more likely to accept the issue. If so, the Supreme Court's ultimate decision will have significant consequences for the ACA. If the Court upholds *Halbig*, around 4.6 million people in the 36 FFM states, including Alabama, who received subsidies in 2014, would lose them, at least going forward.[17] If the subsidies fall, thereby reducing health insurance affordability for some, the viability of the individual mandate may come into question.

B. Narrowing provider networks

One strategy that some insurance carriers implement to reduce premiums under the ACA is to utilize limited or narrow provider networks. The theory goes that the more patient volume a carrier sends its network, the less the providers charge for their services. While the ACA did not birth this practice of narrowing networks, it appears to have accelerated network-shrinking as a means to reduce costs.

Conversely, some insurance companies, including Blue Cross and Blue Shield of Alabama, emphasize network access and offer broad provider networks, while still reducing premiums through operating efficiencies and by helping their members better manage their health.[18] Providing customers the right to choose their own doctors, hospitals and health care remains a priority for certain carriers and seems more in line with the spirit of the ACA.

C. Health care accessibility

Narrow networks diminish the accessibility to health care promoted by the ACA, especially when accounting for the previously suppressed demand from the recently uninsured. In addition to offering broad provider networks, some insurers have expanded their sales channels. Blue Cross and Blue Shield of Alabama recently partnered with Alfa Insurance® to further expand access to Blue Cross and Blue Shield of Alabama individual marketplace plans, utilizing Alfa agents located throughout Alabama.

D. Medical loss ratio refunds

The MLR rule compels health insurers to refund customers if at least 80 percent or 85 percent (depending on plan type) of their premiums are not used to pay for their medical care or quality initiatives. In 2014, 10,342 Alabamians collectively received $990,323 in 2013 MLR refunds,[19] for an average return per Alabamian of around $96. None of the MLR refunds paid in 2012 (first year MLR refunds payable), 2013 or 2014 were paid by Blue Cross and Blue Shield of Alabama. As one of the most efficient health insurers in the industry, in 2013, Blue Cross and Blue Shield of Alabama paid approximately 92 cents of every premium dollar to customers in healthcare benefits, seven cents to operating expenses and less than one penny to income.

Employers' Response To ACA

Now that companies have had some time to digest the ACA, most employers are continuing their commitment to offer health care benefits, focusing on better health care cost controls, avoiding the 2018 so-called "Cadillac" tax on rich benefit plans and increasing employee accountability. One year into the ACA's implementation, a myriad of employer surveys reflect how corporate stakeholders are altering their health care strategies in response to the ACA.

A. "Pay or play?"

Health benefits continue to be very important to companies and workers. Thus far, the ACA has not significantly changed that emphasis. As most employees highly value their health benefits, it is not a surprise that the vast majority of employers seem opposed to dropping health insurance coverage any time soon. A September 2014 Towers Watson employers survey found that 87 percent will not stop subsidizing worker health insurance benefits in 2015 and 83 percent in 2016.[20]

Ninety-nine-and-one-half percent of the employers surveyed have no plans to discontinue providing health benefits and "dump" their employees onto the exchange, with 91 percent not inclined to drop part-time employees' health plans.[21] Similarly, a 2013 Mercer survey found that 94 percent of large employers are committed to offering health coverage for five years.[22] As for small employers that offer coverage to their employees, those with less than 50 employees and the most financially challenged to provide health benefits, only 34 percent say they are "likely" or "very likely" to drop worker health benefits in five years or less.[23]

Alternatively, some small employers have elected to drop coverage as it is cheaper for them to pay the tax than to provide ACA-compliant health benefits. Companies should do the math before deciding to drop coverage. Employers with 100 (transitional rule for 2015) or more full-time-equivalent employees that elect to drop employee health benefits would be assessed a $2,000 per employee penalty under the ACA.[24] Unlike health insurance premiums, the ACA penalties are not tax deductible. If an employer provides a "make whole" payment to assist an employee purchase a marketplace plan, that additional payment would trigger payroll taxes.[25]

B. Health care cost reductions

There are many strategies that employers use to reduce employee health care expenses, including cost shifting, utilizing consumer-directed plans, adopting price or utilization management strategies and holding employees more accountable for making healthy choices. The ACA also appears to have motivated more companies to self-fund their employees' healthcare benefit plans.

While self-funded plans incur risk, the cost savings and benefit design flexibility outweigh that risk for many companies. Sixty-two percent of employers in the Towers Watson survey expect the 18 percent "Cadillac" excise tax will "moderately" or "strongly influence" their health care strategies before the excise tax goes into effect in 2018.[26] Fifty-four percent of employers expect to trigger the excise tax by 2020 if no changes are made to their health benefits.[27]

C. Value-based reimbursement, not Volume-based

The ACA has accelerated a shift from fee-for-service, provider payments based on the quantity of services, to value-based payment models, which focus more on quality, outcomes and provider accountability. Shifting the emphasis of care to outcomes is expected to increase quality of care while reducing employers' healthcare costs. Fourteen percent of the companies in the Towers Watson survey will adopt value-based payment models in their 2015 benefit plans, with another 34 percent considering this transition by 2017.[28]

D. Private exchanges

Private exchanges have arisen pursuant to the ACA and help employers manage their health care spending while allowing their workers to better tailor their health benefits. Consumers desire choice, price and coverage transparency, customized products and an easy way to shop for coverage. Private exchanges have recently emerged to fill these needs and are becoming more common. The employees of a company utilizing a private exchange may shop and choose the health plan that best meets their health needs and budget.

While employer interest in private exchanges is growing, many companies seek confirmation that private exchanges can deliver more savings over the traditional employer-managed model. Twenty-eight percent of companies in the Towers Watson survey investigated transitioning their workers' health benefits to a private exchange.[29] Blue Cross and Blue Shield of Alabama will offer a private exchange–the Alabama Blue Exchange–in early 2015.

E. Second open-enrollment period

The second open-enrollment period began November 15, 2014, and ends February 15, 2015, and is expected to go smoother from a technological standpoint than the initial enrollment period. Unlike the initial enrollment period, this second enrollment must retain current participants while drawing new ones. The Congressional Budget Office forecasts that 13 million people will purchase marketplace plans in 2015. For perspective, around 7.3 million people of the eight million or so who enrolled in the marketplace in 2014 were paying premiums last August. Open-enrollment 2015 may present different challenges as there may not be as much previously unmet demand for coverage as last year. Of course, consumers are better educated about the ACA this year. Consumers needed to enroll[30] in a marketplace plan by December 15, 2014, in order for coverage to be effective January 1, 2015.

Insurer Competition, Marketshare and Profits

Promoting competition among health insurers to reduce premium costs is also one of the ACA's aims. According to the American Medical Association (AMA), Alabama has the least competitive health insurance market of any state, which the AMA imputes to Blue Cross and Blue Shield of Alabama's high market share.[31] However, high market share does not at all necessarily result in higher premiums for consumers.

The Robert Wood Johnson Foundation and the Urban Institute jointly studied 10 states, including Alabama, to ascertain the correlation of market share to premium cost. The study concluded that the ACA has resulted in increased competition and lower premiums. As to Alabama, the report opined that despite the "dominance" of Blue Cross and Blue Shield of Alabama, "premiums are surprisingly low throughout the state; BCBS[AL] did not exercise the market power that it [allegedly] has."[32] The report noted that Alabama had low premiums even though Blue Cross and Blue Shield of Alabama was the sole marketplace insurer in 64 of Alabama's 67 counties in 2014.

Criticizing health insurers for rising health plan premiums has become somewhat of a sport over the last few years, but the reality is that insurer profits constitute a nominal part of U.S. health spending. Carriers spend premium revenue on patients' medical services, medications and new medical procedures. Most health insurance companies' profits are small, about 3.2 percent versus the 16.67 percent net profit margin of the healthcare sector as a whole, with drug companies running net profit margins of around 20.80 percent.[33] Reducing insurer profits will do little to decrease our nation's healthcare spending.

Conclusion

At the conclusion of the first year of the ACA's implementation, consumers, employers and health insurers know more about the ACA than ever before. While the ACA and health care industry will continue to evolve, there is so much more to learn about the ACA and its aftereffects over the next few years.

How the ACA evolves going forward is largely up to our politicians. Can they work together to improve the ACA, including its inadvertent consequences? There is little doubt that the ACA will mature. Let's hope the changes will further the ACA's goals of providing more consumers access to affordable, quality health care. | AL

Endnotes

1. The Patient Protection and Affordable Care Act, Pub. L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, enacted on March 30, 2010, are collectively referred to as the Affordable Care Act.
2. The Court upheld the constitutionality of the individual mandate, the crux of the appeal, and ruled that Congress properly increased funding to expand Medicaid, but that the United States could not "coerce" states to expand Medicaid programs by withholding existing Medicaid programs' federal funding if a state elected not to expand its Medicaid program.
3. Four years from passage, public opinion of the ACA persists to be more negative (47 percent) than positive (35 percent). Even so, a majority of people desire to fix the ACA (63 percent) over repealing and replacing it (33 percent). Kaiser Family Foundation, *Kaiser Health Tracking Poll: August-September 2014*, pp. 1, 5.
4. Since 1936, Blue Cross and Blue Shield of Alabama has been committed to providing Alabamians access to quality, affordable health care by offering the largest network of hospitals, physicians, pharmacies and other providers in Alabama. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.
5. Kev Coleman, *Almost No Existing Health Plans Meet New ACA Essential Health Benefit Standards* (March 7, 2013), available at *http://www.healthpocket.com/healthcare-research/infostat/few-existing-health-plans-meet-new-aca-essential-health-benefit-standards*.
6. Department of Health and Human Services ASPE Research Brief, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace*, p. 23 (June 18, 2014).
7. *Id.*
8. *Id.*
9. The ACA requires each state to stand a health care exchange on its own, in partnership with the federal government or to participate in the FFM operated by our federal government. In 2014, 36 states, including Alabama, participated in the FFM.
10. Department of Health and Human Services ASPE Research Brief, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace*, p. 26 (June 18, 2014).
11. Kev Coleman, *Without Subsidies Women & Men, Old & Young Average Higher Monthly Premiums with Obamacare* (October 29, 2014), available at *http://www.healthpocket.com/healthcare-research/infostat/obamacare-2014-premiums-higher-than-pre-reform-market*.
12. *Id.*
13. No. 14-5018.
14. No. 14-1158.
15. No. CIV-11-30-RAW.
16. No. 1:13-CV-1612.
17. Larry Levitt and Gary Claxton, *The Potential Side Effects of Halbig*, Kaiser Family Foundation (July 31, 2014).
18. Blue Cross and Blue Shield of Alabama is committed to ensuring customers receive the highest quality medical care at an affordable price. Some initiatives implemented to help influence health care costs and premiums include encouraging members to adopt healthier lifestyles, partnering with doctors and hospitals to implement programs that improve health care quality and negotiating prices with hospitals and physicians to keep costs for medical treatments as affordable as possible.
19. *www.CMS.gov, 2013 MLR Refunds by State* (2013).
20. Towers Watson, *2014 Health Care Changes Ahead Survey*, p. 3 (September 2014).
21. *Id.*
22. Mercer, *Mercer's National Survey of Employer-Sponsored Health Plans* (2013).
23. *Id.*
24. For 2015, subtract 80 from the number of full-time equivalent (FTE) employees and then multiply that number by $2,000 to calculate the penalty. In 2016 and beyond, subtract 30 from the number of FTEs for penalty calculation purposes.
25. In order for employees to be eligible for subsidies on the individual exchange, companies cannot increase a worker's salary through a tax-exempt savings account, like an HRA.
26. Towers Watson, *2014 Health Care Changes Ahead Survey*, p. 5 (September 2014).
27. *Id.*
28. *Id.* at p. 6.
29. *Id.* at p. 7.
30. While the ACA allows people to automatically renew their 2014 coverage for 2015, consumers with changed incomes should reapply to determine the extent of subsidy eligibility and avoid any potential tax surprises later.
31. American Medical Association, *Competition in Health Insurance, A Comprehensive Study of U.S. Markets* (2014).
32. John Holahan, *Will Premiums Skyrocket in 2015?*, p. 3, Robert Wood Johnson Foundation and Urban Institute (May 2014); John Holahan and Linda Blumberg, *Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act*, pp. 4, 15, Robert Wood Johnson Foundation and Urban Institute (August 2014).
33. *http://biz.yahoo.com/p/5qpmd.html*.