



The Patient Protection and Affordable Care Act Beyond the Horizon into 2015

ACA Critical Issues – Part II



April 2014

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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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Preface

ACA Critical Issues – Part II

The Physicians Foundation

The deeply challenging initial open enrollment period of the Affordable Care Act closed on March 31, 2014 (except for time-limited provisions offered by the federal government and about 10 states to complete certain enrollments begun during the open period.) Based on preliminary data, about 7.5 million individuals enrolled in private plans through the federal and state exchanges. An estimated 3 million enrolled in Medicaid through existing and expanded state programs, although half of the states opted-out of the Medicaid expansion opportunity under the ACA.

These early ACA numbers *will change* and be dissected by enrollees' enrollment completion rates, age, prior insurance status, health characteristics and other factors. Private plans' data will receive equally close scrutiny: participation levels, products offered, premium levels, products sold, early medical and drug claims experience, profit margins, marketing issues, and adequacy of provider networks. This leads rapidly into federal and state exchanges' Round 2 evaluations and approval of plan offerings for the next open enrollment period scheduled to run from November 15, 2014 to February 15, 2015, a more compressed schedule.

In a real sense, variations in state politics, policies and operations may be the larger story unfolding behind the ACA's progress. The federal government, many states and the District of Columbia made landscape-altering fiscal and management investments in changing the rules for the offering of private health insurance in the U.S., and in expanding public programs for lower-income families and individuals. Other states have not made

comparable investments, raising serious equity and access issues across states. Along with the federal exchange's performance, state actions and results, successful and unsuccessful, are coming under close scrutiny.

The future of the ACA is being contested on many fronts: in the U.S. Congress, in Governors' mansions and state legislatures, in the courts, among health care providers, and most importantly, around the kitchen tables of ordinary Americans. Battle lines are being drawn in the Congressional and state races for the 2014 mid-term elections to be held on November 4, 2014. Majority control of the House and Senate in the U.S. Congress and thirty-six Governors' seats are at stake.

Practicing physicians are on the frontlines of the ACA debates. Doctors continue to care for their patients in the midst of deep challenges affecting their practices: adoption of electronic health records and new quality measures, data reporting requirements and complex new payment models. Physicians must engage in continuing medical education, and must also stay abreast of challenging public policy and market shifts that affect their practice models and how they care for their patients. In a different sort of landscape-altering action, the federal Centers for Medicare and Medicaid Services released nationwide in April, personally identifiable physicians' and other suppliers' charges, payments, billing codes and place of service data for all Medicare services provided by them to Medicare patients in the year 2012. This public use data set is presented by CMS as a federal effort "to make the healthcare system more transparent, affordable and accountable."

It is the mission of The Physicians Foundation to help educate physicians about these broad public policy and health care market dynamics. The following report, ACA Critical Issues—Part II, provides a current overview of the ACA's political and budget dynamics, its initial successes and failures, and its most serious challenges going forward into 2015. We also focus on physician matters such as new federal network adequacy standards for health plans, and newly enacted Medicare program legislation. We are pleased to offer this report--the fifth in a series of educational reports on the ACA. We also wish to draw your attention to a further report scheduled for release by the Foundation this summer focusing exclusively on the Medicare program as a notable instrument of health care system reform. Among other major issues to be addressed in that report, we will consider the longer-term implications of the physician (and earlier hospital) data releases.

In closing, President Obama announced recently he had accepted the resignation of Kathleen Sebelius, his Cabinet Secretary for the Department of Health and Human Services. Secretary Sebelius had presided over the extraordinarily complex Department for five years, a tenure that most recently encompassed the flawed rollout of the federal exchange website known as HealthCare.gov. The President's new nominee for the position, Sylvia Mathews Burwell, is the current and well-regarded Director of the Office of Management and Budget. As we go to press, Director Burwell begins her challenging journey towards U.S. Senate confirmation in a politically hyper-charged environment.



The President's Legacy Redux

Just over one full year into his second term, President Barack Obama's legacy is still being shaped across many dimensions, domestic and international. Our preceding report titled "ACA Critical Issues—Part I," noted that the Patient Protection and Affordable Care Act (the ACA) is a defining test of his Presidency and legacy. The tenets of this sweeping federal law range from large health insurance coverage expansions, provider payment, quality and technology reforms, important changes to the existing Medicare and Medicaid programs, and deep interventions into the private employer and commercial health insurance markets. In short, the law is reshaping the American health care system.

The immediate "Situation Critical" issues surrounding the troubled initial rollout of the federal and state health insurance exchanges last October are moderating. States' Medicaid program expansion decisions have been crucial to the overall coverage expansions, and some of the states that originally declined to expand Medicaid are reconsidering and exploring possible models for doing so in the future. The Administration soldiers on as opponents seize on any and all new targets that emerge. Perhaps that explains why the ACA received only one line out of 27 priorities enumerated

in the 2014 State of the Union "pocket-card" handed out by the Administration to Members of Congress. That slightly cryptic line read simply: "Keep moving forward to expand the security of quality, affordable health care to all working Americans." Definitely sounds "hunkered down."

From the perspective of most health care professionals it is very important that individuals have secure means by which to access and afford needed health services. There is a strong body of research that reveals poorer health status and higher morbidity and mortality rates for long-term uninsured populations compared to insured populations. This is separate from the devastating impact a severe injury or illness can have upon the economic status of an individual or family, especially when the person or family lacks health insurance protection.

Preliminary ACA enrollment figures, while not yet finalized as of this writing, suggest that the ACA has helped about 9.5 million individuals secure coverage through exchange policies or via Medicaid enrollment. Equally clear is that the large-scale coverage transitions are complicated and expensive for some, and that health systems, physicians, and other providers feel burdened by many ACA-related quality, payment, reporting

Progress under the ACA, or any health system reform, may be deeply challenged by a lack of health *insurance* literacy across the U.S. population. This complicates the Obama Administration's and states' educational and enrollment efforts, and surely adds to individuals' confusion and vulnerability to misinformation as the complicated ACA provisions unfold.

and other new requirements. Many aspects of the law, and the detailed policies by which the law is being carried out, continue to be subject to lawsuits, political opposition, technology issues, regulatory changes by the Administration (perhaps out of administrative necessity), and widespread consumer confusion.

In preparing this report, we were struck time and again by the apparent undertow of health illiteracy across the United States. All physicians grapple with trying to overcome the literacy challenges (educational, language, cultural and other barriers) that interfere with patients' understanding of and compliance with health information and medical care regimens. Progress under the ACA, or any health system reform, may be deeply challenged by a lack of health *insurance* literacy across the U.S. population. This complicates the Obama Administration's and states' educational and enrollment efforts, and surely adds to individuals' confusion and vulnerability to misinformation as the complicated ACA provisions unfold. These problems may influence voter perspectives and voter behavior in the 2014 mid-term elections. While deeper examination of health literacy concerns is outside the scope of this report, it is important to consider whether and how health *illiteracy* is a factor in the ACA's progress and/or failures.

We summarize briefly these initial ACA rollout challenges. Indeed, the Administration reported that HealthCare.gov experienced several million visitors in its final few days of the 2014 open enrollment period, leading to temporary periods of failed operation. It is likely that such issues damaged the environment in which the ACA is being implemented and perhaps suppressed initial public acceptance and total enrollment figures in the first open season. It is important to diagnose and correct 2014's policy and operational issues, in order to a) improve future performance in the market function of exchanges, b) to achieve well-functioning individual and small-employer insurance markets, and Medicaid programs, in every state, and c) to maximize participation by eligible individuals, nationwide. Therefore, our principal objective in this report, after setting the stage, is to look forward to 2015 and beyond, considering both opportunities for and fresh challenges

to the ACA going forward. As always, within the broader context, we particularly examine select issues of particular import to practicing physicians.

Following is a synopsis of the report's organization:

CHAPTER I > **CBO Speaks, The 2014 Mid-Term Elections, and Assessing the Initial Coverage Rollout**

—As an essential backdrop, we provide perspectives and key data shaping the latest fiscal, political and other forces impacting upon the future progress of the ACA. This includes the ground-shifting federal budget re-estimates and analyses of the ACA released in February by the Congressional Budget Office. We discuss unfolding Congressional Republican and Democratic parties' positioning for the 2014 mid-term elections. Will the Republican Party's continued opposition to the ACA strengthen the Republican candidates' position in those elections? We also focus attention on the 36 Gubernatorial races, the President's job approval ratings and the public's current perceptions of the ACA.

CHAPTER II > **The Private Health Insurance Market: Coverage Expansions, Regulatory Oversight and Reform Roles**

—The private HI market is increasingly a lynchpin for the aspirations of health care financing and delivery system reform in both major political parties. This is so not just for the ACA private HI marketplace, but for the Medicaid and Medicare programs, as well. For instance, in Medicare, the private health insurance market is central to the design and delivery features of the Medicare Part D drug benefit, the Medicare Advantage program, and potential proposals to convert the overall Medicare program into a "premium support" model. Private insurers also underpin many States' Medicaid benefit delivery, management, and cost-control programs.

We examine the status nationwide of ACA-sponsored coverage expansions, implementation, and issues heading into 2015. We note differences in the health reform debate of the 1990's contrasted with the enactment of the ACA. Finally we consider what might be the key metrics by which to judge the ACA looking forward.

CHAPTER III > Key ACA Challenges for Private Medical Practice

In every report in this series, the Physicians Foundation’s driving concern has been the extent to which the ACA is re-shaping the delivery of health care by physicians to patients. Our goals are two-fold. The ACA is a piece of major legislation that occurred in a particular political and fiscal environment and reflects the societal objectives of its framers. Our society, politics and fiscal issues are all dynamic. So our first goal is to help keep physicians informed of the larger forces operating in those spheres and how they may be changing even as the ACA unfolds. The law will be changed. The question is how, when and by whom?

Our second goal is to review numerous ACA-based provisions that directly impact upon the private practice of medicine and select a few timely issues of import to physicians for special attention. In this report, we provide updates on the Medicare physician fee schedule, emerging physician-insurer network and contracting issues, and new Medicare legislation. In our ACA Critical Issues—Part I report, we flagged the importance for physicians and their patients of the “network adequacy” requirement of the law, and how vulnerable it is to subjective interpretation by insurers. The issue of provider contracting and “network adequacy” in health insurance plans participating in the ACA’s health insurance exchanges is real and is now gaining further federal and state attention.

We close this report by highlighting our plans for an upcoming report on the Medicare program, which focuses on how the ACA is effectuating systemic health system changes through the regulatory power of Medicare.

An Editorial Word on the ACA Series—The Physicians Foundation is pleased to add this report to its multi-year series of informative and educational reports, surveys and other materials addressing the transformation of the American health care system. The Foundation’s goal, as always, is to assist practicing physicians in understanding and successfully navigating key systemic changes impacting directly upon the practice of medicine.

This report, *ACA Critical Issues—Part II*, is the fifth in a series of reports examining the Patient Protection and Affordable Care Act of 2010 (the ACA), initiated shortly after enactment. All five reports are available in electronic form on our website at the following address www.physiciansfoundation.org under the following titles:



- 1 > A Roadmap for Physicians to Health Care Reform (May 2011)
- 2 > The U.S. Health Care Highway—2012; Medical Practice in an Era of Economic and Health Care Reform Challenges (August 2012)
- 3 > The U.S. Health Care Highway—2012; Part II: Crossing the Election Divide, Health Care Reform Gateway to 2013 (January 2013), and
- 4 > The Patient Protection and Affordable Care Act—From Theory to Boots on the Ground; ACA Critical Issues—Part I (November 2013). These are followed by this report:
- 5 > The Patient Protection and Affordable Care Act—Beyond the Horizon Into 2015; ACA Critical Issues—Part II (April 2014)

The initial “Roadmap” report provides a substantive overview of key legislative authorities and features under the ACA, as enacted, with a special focus on numerous provisions of particular interest to practicing physicians. Each of the subsequent reports provides factual information and non-

partisan commentary on select requirements of the law and implementing regulations as they have unfolded. Topics relate to key ACA implementation actions, facts and challenges, perspectives on federal and state political and budget issues, and most importantly, on select areas of specific interest to physicians in medical practice. Each report, including this one, “telescopes” from a broad survey of the shifting, larger environment to a closer look at physician-specific issues.

This report, ACA Critical Issues—Part II, is organized into three chapters:

Chapter I—The ACA: CBO Speaks, Shadow of the Mid-Term Elections, and A Deeper Assessment of the Initial Coverage Rollout

Chapter II—The ACA: The Changing American Health Care Marketplace

Chapter III—Critical ACA Challenges and Perspectives for Physicians

Turning now to Chapter I, the Physicians Foundation’s Board of Directors thanks you in advance for your time and attention.





Chapter I ➤ The ACA: CBO Speaks, Shadow of the Mid-Term Elections, and Assessing the Initial Coverage Rollout

Introduction

ACA Rollout Rocks the Law's Foundations—Most Americans, whether supporters or detractors, recognize that major failures in leadership and technology rocked the foundations of the coverage rollout of the Patient Protection and Affordable Care Act (ACA) in the fall of 2013. Lest readers think it is all about the failures of the federal exchange and website, HealthCare.gov, several states operating their own exchanges also failed significantly. As we discuss later, the underlying issues leading to these problems are under investigation by the Congress, the General Accountability Office, and the federal Inspector General(s) of the Department of Health and Human Services and other federal agencies.

In the meantime, technical website repairs and “work-arounds” largely took hold. Looking forward, real performance improvements in the federal and state exchanges, and in Medicaid enrollments, can be accomplished in the interim before the 2015 open enrollment period begins.

In the balance of the report, we provide information and perspectives regarding many of these issue areas. However, we focus first on the important federal fiscal backdrop concerning the nation’s economic outlook, and the estimated costs and other implications of the ACA, as recently outlined by the Congressional Budget Office (CBO).

I. The CBO Speaks: Federal Spending, the Impact of the ACA and Jobs

Overview—CBO plays a uniquely important role in the U.S. Congress. Founded in 1974, the CBO was created by the Congress to be an effective counterpoint in the Legislative Branch to the budgetary power and authority of the Office of Management and Budget (OMB) in the Executive Branch of government. The Congressional Budget and Impoundment Control Act of 1974 created “new legislative institutions to implement the new Congressional budget process,” the House

Nongroup Health Plans Under the Affordable Care Act

Starting in 2014, companies that sell nongroup insurance plans, whether through the exchanges or not, must—in most cases—follow certain rules specified in the Affordable Care Act (ACA).¹ All new plans, for example, must cover a set of essential health benefits, and their premiums may not vary among enrollees on the basis of health. Insurers selling nongroup plans through the exchanges must offer at least one “silver” plan (with an actuarial value of 70 percent) and one “gold” plan (80 percent).² Insurers selling plans outside of the exchanges must follow the same system of “metal” tiers, ranging from 60 percent (“bronze”) to 90 percent (“platinum”), but, unlike insurers in the exchanges, they are exempt from the requirement to offer at least one silver and one gold plan.³ Plans must be available for anyone to purchase during specified annual open-enrollment periods and, outside of those periods, to anyone who experiences a qualifying life event, such as the birth of a child or a change in employment. States may impose additional requirements on insurers that offer nongroup coverage inside or outside of the exchanges.

Because of the uncertainty about average health care costs for people enrolling under the new rules governing the nongroup market, plans that comply with the ACA’s rules are protected from some of the risk that they will attract enrollees whose health care costs will prove to be especially high.⁴ The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) expect that people who purchase ACA-compliant plans outside of the exchanges would probably not have been eligible for subsidies had they obtained coverage through the exchanges and that many would have purchased coverage in the nongroup market in the absence of the ACA.

Under certain limited circumstances, insurers are allowed to continue to sell policies that do not comply with the ACA’s rules. Such noncompliant policies, for example, might not cover all of the essential benefits specified in the ACA, might have an actuarial value of less than 60 percent, or might charge lower premiums for people in better health.⁵ Those limited circumstances include the following:

- Some policies can be “grandfathered” in. Policies that were in effect in March 2010 and that have been maintained continuously without substantial changes in benefits or in costs to enrollees are exempt from most of the ACA’s rules.
- Some states permitted insurers to allow enrollees to renew policies that did not comply with certain market and benefit rules for 2014 so long as the policy year began before January 1, 2014.
- Some policies can qualify under what is known as transitional relief. In November 2013, the Administration announced that states could accept renewals of noncompliant policies for a policy year starting between January 1, 2014, and October 1, 2014. In

March 2014, that transitional relief was extended for two more years. (More detail on recent administrative actions that affect noncompliant plans is provided in “Availability of Noncompliant Plans” in the main text.) CBO and JCT estimate that relatively few people will be enrolled in noncompliant nongroup plans. The agencies project that, under the ACA, in 2014 about 2 million people will purchase noncompliant plans; they anticipate that enrollment in such plans will decline to negligible numbers by 2016. They also project that enrollment in nongroup plans through the exchanges will average 6 million people in 2014, 13 million in 2015, and 24 million or 25 million each year thereafter, and that roughly 5 million people will enroll in ACA-compliant plans outside of the exchanges each year from 2014 through 2024. That last estimate is especially uncertain because information on the number of people who have purchased coverage in the nongroup market in past years is incomplete and varies widely by data source. In the absence of the ACA, 9 million to 10 million people would have enrolled in nongroup coverage each year from 2014 through 2024, CBO and JCT estimate. With roughly 5 million people expected to enroll in nongroup plans in years after 2015 under the ACA (excluding those people who purchase policies through the exchanges), that number will be 4 million to 5 million lower under the ACA than the number projected in the absence of the law (see the change in coverage labeled “Nongroup and other coverage” in Table 2 of the main text).

1. Nongroup plans are those sold to individuals and families rather than to employers or groups of people.
2. A plan’s actuarial value is the share of costs for covered services that it would pay, on average, with a broadly representative group of people enrolled.
3. People under 30 years of age and those who qualify for certain exemptions from the individual mandate penalty also may purchase catastrophic coverage inside or outside of the exchanges. Such plans incorporate the ACA’s set of essential health benefits, but they are not required to meet a minimum actuarial value of 60 percent. Catastrophic plans have a high deductible that is equal to the plan’s out-of-pocket maximum and do not qualify for premium or cost-sharing subsidies, even when offered through the exchanges.
4. Among the federal safeguards that reduce the risk are the risk adjustment and reinsurance programs (which apply to all ACA-compliant nongroup plans), and risk corridors (which cover all exchange plans and also include certain plans offered outside the exchanges); for more discussion, see Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, Appendix B (February 2014), www.cbo.gov/publication/45010.
5. Insurers may also sell other policies that are service specific (including dental and vision), that cover accidental injury or specific diseases, or that are in effect for only a short time; such plans do not, on their own, count as providing minimum essential coverage under the ACA. Such plans are not included in CBO and JCT’s estimates of coverage under the ACA.

SOURCE: CBO AND JCT

and Senate Budget Committees to oversee the process, and the CBO to provide the Congress with “objective, impartial information about budgetary and economic issues.” (CBO.gov/our founding).

Noted economist Alice M. Rivlin served for over eight years as CBO’s first Director. The current Director is Douglas W. Elmendorf who began serving on January 22, 2009. All CBO Directors are appointed with the informal agreement of the Majority and Minority leaders on the Budget Committees and House and Senate leadership. CBO as an institution and its Directors are expected to observe high professional standards and non-partisanship in their work. CBO’s credibility and influence is tied fundamentally to its professionalism and independence from undue political influence over its work and any economic conclusions or budgetary impact estimates derived from that work.

CBO’s Economic Outlook Releases—Early in February, CBO released its typical, annual reassessment of the economy and its 10-year forecast and baseline budget projections. These were contained in “The Budget and Economic Outlook: 2014-2024” and accompanying appendices. The baseline projections form the basis for estimating the savings or costs (“scoring”) of any new legislation that might proceed from the Congress into next year, for instance, on tax reform, immigration, entitlement or other programs.

For legislative scoring reasons alone, CBO’s baseline, incorporating its assumptions and projections on the economy and on federal programs under current laws, would be a highly fraught political topic. However, a particular subset of these budget releases created controversy over the impact of the ACA on employment, amplified by existing political issues over the sluggish economy and proposals to raise the federal minimum wage. These became the basis for a new angle of attack for factions opposing the ACA.

A Dispute Breaks-Out Over Labor Market Implications of the ACA—In testimony and in Appendix C accompanying the 2014 Budget Outlook report, CBO provided details on its projections that while economic growth is estimated to be

solid in the near-term, weakness in the labor market will likely persist. Relatedly, CBO issued in February 2014, a companion report titled “The Slow Recovery of the Labor Market.” These reports, and related testimony and blog posts, include complex considerations of the effect of the ACA on the labor markets.

Theoretical labor market issues are outside the scope of this report, but we note that CBO posited that the availability of health insurance coverage and subsidies under the ACA would cause an estimated 2.5 million workers (over the prospective 10-year budget window) to change their employment decisions or exit the employer market. CBO took care to note that it was not correct to characterize their ACA labor market estimates as “the ACA causes loss of jobs.”

Rather, CBO noted that the ACA could reduce “job-lock” for a subset of individuals whose employment decisions are sub-optimally shaped by their desire or need to secure employer-based health insurance. If reasonably accessible individual health insurance market products were available that are not tied to employment, some workers would change their working status. This is not necessarily negative; this could free individuals to enter more flexible, part-time or entrepreneurial work pursuits. In an economic sense, it is theoretically possible that reduced labor supply could lead to improved wages for those remaining in the employer-based labor force. For more information, interested readers are referred to the source materials at www.CBO.gov under the 2014 Budget Outlook tab.

Major CBO ACA April Updates—On April 14, CBO and the Joint Committee on Taxation (JCT) released two separate reports presenting significant updates to the February Budget Outlook, and new analyses and projections related to their previous enrollment and cost estimates under the ACA. The first was titled *Updated Budget Projections: 2014 to 2024*, and the second was titled *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act, April 2014*.

We highlight select findings, but also commend

Future federal spending will be boosted by aging of the population, expansion of federal subsidies for health insurance, rising health care costs per beneficiary and mounting interest costs on federal debt.

CBO lowered its ACA cost estimates, in part, due to lower than expected plan premium levels in the initial open enrollment period.

the source reports to interested readers for a deeper understanding of the complex interactions that the ACA is estimated by CBO and JCT to have upon coverage, insurance markets, federal tax revenues and spending, federal deficits, and even programs such as Social Security.

The following information is abstracted from the second report cited above. CBO and JCT note the following:

1 > Key Estimation Factors—The report lists the following key elements of the ACA’s insurance coverage provisions that impact upon and are encompassed by their estimates:

- The ACA allows many individuals and families to purchase subsidized insurance through the exchanges (or marketplaces) operated either by the federal government or by a state government.
- States are permitted but not required to expand eligibility for Medicaid.
- Most legal residents of the United States must either obtain health insurance or pay a penalty for not doing so (the individual mandate).
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards will be assessed penalties.
- A federal excise tax will be imposed on some health insurance plans with high premiums.
- Most insurers offering policies either for purchase through the exchanges or directly to consumers outside of the exchanges must meet several requirements: For example, they must accept all applicants regardless of health status; they may vary premiums only by age, smoking status, and geographic location; and they may not limit coverage for preexisting medical conditions.

Certain small employers that provide health insurance to their employees will be eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

CBO notes that the ACA also made other changes to rules governing health insurance coverage, such as coverage in the non-group,

small-group, and large-group markets, in some cases including self-insured employment-based plans.

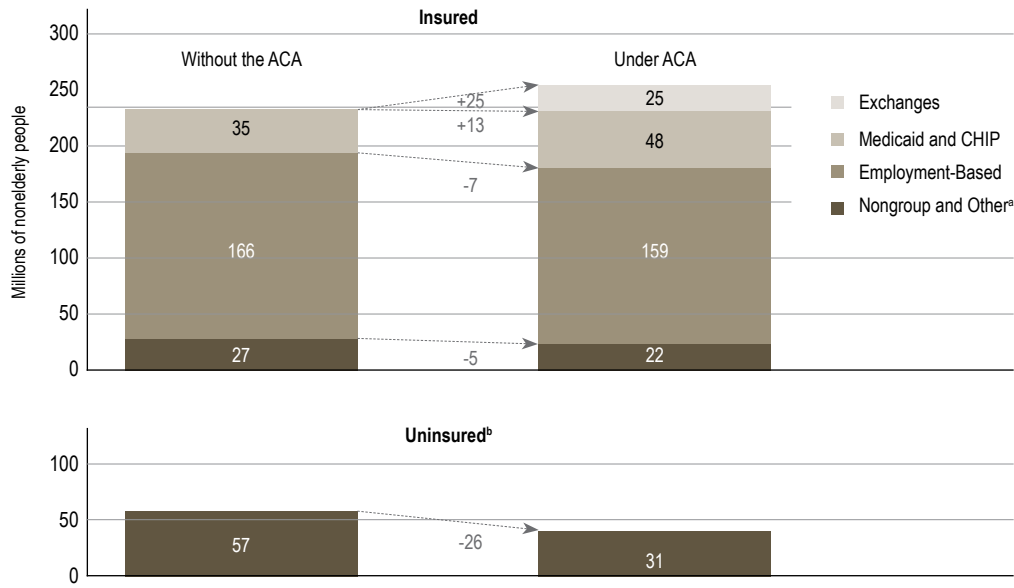
2 > Aggregate Insurance Coverage Costs—CBO and JCT currently estimate that the insurance coverage provisions of the ACA will have a net cost over the 2015–2024 period that is \$104 billion less than they estimated in February 2014. The difference stems from the following changes in estimates of the government’s spending and collections

- A reduction of \$165 billion (or 8 percent) in the gross cost of the coverage provisions, almost entirely because exchange subsidies and related spending are now projected to cost \$1,032 billion, compared with the previous estimate of \$1,197 billion; and
- A partially offsetting net reduction of \$61 billion in savings as a result of lower expected penalty payments from uninsured people and employers, higher expected revenue resulting from the excise tax on certain high-premium employment-based insurance plans, and lower savings from other budgetary effects (mostly decreases in tax revenues).
- To illustrate this lowered budgetary cost estimate effect, note that CBO and JCT projected in *March 2010* on passage that the ACA’s insurance coverage provisions would have a net federal cost of \$172 billion in 2019; the current projections show a cost of \$144 billion in 2019—a reduction of 16 percent.

3 > Projected Coverage Levels—CBO and JCT estimate that despite substantial increases in health insurance coverage projected under the ACA, many will remain uninsured at the levels, and for the reasons, shown in Figure 1 from the report.

4 > Medicaid and CHIP Costs—It is now estimated that the added costs to the federal government for Medicaid and CHIP attributable to the ACA will be \$20 billion in 2014 and will total \$792 billion for the 2015–2024 period. This is based on increased enrollment of individuals in traditional Medicaid, as well as expanding state programs under the ACA’s expanded coverage and financing provisions.

FIGURE 1. EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE, 2024



SOURCES: CONGRESSIONAL BUDGET OFFICE; STAFF OF THE JOINT COMMITTEE ON TAXATION.

Notes: The nonelderly population consists of residents of the 50 states and the District of Columbia who are younger than 65. ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

a. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

b. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

CBO TABLE 4. COMPARISON OF CBO AND JCT'S CURRENT AND PREVIOUS ESTIMATES OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT

	February 2014 Baseline	April 2014 Baseline	Difference
Change in Insurance Coverage Under the ACA in 2024 (Millions of nonelderly people, by calendar year)^a			
Insurance Exchanges	24	25	*
Medicaid and CHIP	13	13	1
Employment-Based Coverage ^b	-7	-7	-1
Nongroup and Other Coverage ^c	-5	-5	*
Uninsured ^d	-25	-26	-1
Effects on the Cumulative Federal Deficit, 2015 to 2024^e (Billions of dollars)			
Exchange Subsidies and Related Spending ^f	1,197	1,032	-164
Medicaid and CHIP Outlays	792	792	**
Small-Employer Tax Credits ^g	15	15	**
Gross Cost of Coverage Provisions	2,004	1,839	-165
Penalty Payments by Uninsured People	-52	-46	6
Penalty Payments by Employers ^g	-151	-139	12
Excise Tax on High-Premium Insurance Plans ^g	-108	-120	-12
Other Effects on Revenues and Outlays ^h	-206	-152	54
Net Cost of Coverage Provisions	1,487	1,383	-104
Memorandum: Net Collections and Payments for Risk Adjustment, Reinsurance, and Risk Corridorsⁱ	-8	0	8

SOURCES: CONGRESSIONAL BUDGET OFFICE; STAFF OF THE JOINT COMMITTEE ON TAXATION.

Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between zero and 500,000; ** = between -\$500 million and \$500 million.

a. Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

b. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

c. "Other" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

d. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, an exchange, or directly from an insurer.

e. Positive numbers indicate an increase in the deficit; negative numbers indicate a decrease in the deficit. They also exclude effects on the deficit of other provisions of the ACA that are not related to insurance coverage, and they exclude federal administrative costs subject to appropriation.

f. Includes spending for exchange grants to states and net collections and payments for risk adjustment, reinsurance, and risk corridors (see "Memorandum").

g. These effects on the deficit include the associated effects of changes in taxable compensation on revenues.

h. Consists mainly of the effects of changes in taxable compensation on revenues.

i. These effects are included in "Exchange Subsidies and Related Spending."

5 > Employment-Based Coverage Interactions/Deficit Reduction Effects—The ACA also will affect federal tax revenues because fewer people will have employment-based health insurance and thus more of their income will take the form of taxable wages. CBO and JCT project that, as a result of the ACA, between 7 million and 8 million fewer people will have employment-based insurance each year from

have been the case. That shift in compensation will boost federal tax receipts. Partially offsetting those added receipts will be an estimated \$7 billion increase in Social Security benefits that will arise from the higher wages paid to workers. *All told, CBO and JCT project those effects will reduce federal budget deficits by \$152 billion over the 2015–2024 period.* Due to the significant shifts in these estimates relative to the February baseline, and the Congressional attention this receives for both political and practical future legislation scoring reasons, we have included Table 4 from the report depicting the key changes.



CBO's Updated Baseline Budget Projections for Health Care Entitlement Programs—The following information is derived from CBO's companion report released on April 14, 2014 and titled *Updated Budget Projections: 2014 – 2024*. We highlight select information concerning entitlement programs and newly enacted law, including references to Medicare physician services.

CBO first states that: “CBO’s baseline projections are not a forecast of future outcomes. They are constructed in accordance with provisions set forth in the Balanced Budget and Emergency Deficit Control Act of 1985 and the Congressional Budget and Impoundment Control Act of 1974. As those laws specify, CBO constructs its baseline projections under the assumption that current

2016 through 2024 than would have been the case in the absence of the ACA. That difference is the net result of projected increases and decreases in offers of health insurance from employers and of choices about enrollment by active workers, early retirees (people under the age of 65 at retirement), and their families.

Because of the net reduction in employment-based coverage, the share of workers’ pay that takes the form of nontaxable benefits (such as health insurance premiums) will be smaller—and the share that takes the form of taxable wages will be larger—than would otherwise

laws will generally remain unchanged; the projections can therefore serve as a benchmark against which potential changes in law can be measured. However, even if federal laws remained unchanged for the next decade, actual budgetary outcomes could differ from CBO’s baseline projections, perhaps significantly, because of unanticipated changes in economic conditions and other factors that affect federal projections. CBO’s updated baseline incorporates the effects of legislation and administrative actions through April 1, 2014.”

CBO's baseline projections serve as a benchmark for scoring the future costs or savings of new legislation.

Medicare—CBO’s current projection of net mandatory spending for Medicare is \$98 billion (1.4 percent) lower over the 2015–2024 period than the agency’s projection in February. The major component of that change is a reduction of \$56 billion in projected spending for prescription drugs covered by Part D.

Projected net outlays for Parts A and B are slightly higher (by a total of \$14 billion) from 2015 through 2017 and lower in subsequent years than they were in the previous baseline. *The higher projected spending in the next few years is largely the result of recent data that show greater-than-anticipated spending for physicians’ services in 2013 (emphasis supplied).* The lower projected spending in subsequent years stems from two factors. First, although recent legislation temporarily (through March 2015) overrides the formula used to determine payment rates for physicians’ services, that formula—if left in place—will reduce payment rates in subsequent years to recoup the higher spending in the next few years. Second, after analyzing recent trends, CBO has slightly reduced projected rates of growth for many other categories of Part A and Part B services.

Medicaid—CBO has increased its projection of Medicaid spending by \$29 billion (0.6 percent) over the 2015–2024 period. That increase is the net effect of a variety of small changes, but it does reflect an increase in the number of people eligible for and enrolled in Medicaid.

The Protecting Access to Medicare Act of 2014 (P.L. 113-93)—The new law extended current payment rates for physicians’ services through March 31, 2015; extended a number of health care and human services programs and provisions that would otherwise have expired; and made other modifications to Medicare, Medicaid, the Children’s Health Insurance Program, and several human services programs. *The extension of current payment rates for physicians’ services, along with some smaller changes, increased estimated outlays for 2014 by \$6 billion (emphasis supplied).* For the 2015–2024 period, P.L. 113-93 reduced projected mandatory outlays by an estimated \$7 billion, primarily by reducing payment rates for Medicare services (including a 4 percent across-the-board reduction in payment rates

for services furnished during the last six months of fiscal year 2024) and by reducing Medicaid payments to hospitals that serve a disproportionate share of low-income and uninsured patients.

Please refer to Chapter III under “Medicare Matters” for an enlarged compilation of the legislated changes enacted under P.L. 113-93.

Medicare Increases—Under current law, the number of beneficiaries of Medicare will increase by more than a third over the next decade. That will occur simply because the number of Americans over age 65 will increase by more than a third.

Average Health Spending Trends—Under current law, CBO projects that average spending per person in Medicare will increase much more slowly during the next decade than it has during the past few decades, due primarily to three factors:

1 > Constraints on payment rates built into current law—CBO states “the sustainable growth rate mechanism for payments to doctors (which will probably be modified in one way or another) will account for some of that effect, but most will stem from the constraints on payments imposed by the ACA (which might later be modified as well.)” We note that MedPAC, in its March 2014 Report to Congress, continues to call for flat payments for several provider categories under the Medicare program.

2 > Slow growth during the past several years in the quantity and intensity of health care services provided per beneficiary—CBO finds the slowdown has been broad, persistent, and extends across all types of Medicare services, beneficiaries, and major regions, as well as Medicaid and private health insurance. CBO states it expects slower growth to continue for a number of years.

3 > An anticipated influx of beneficiaries turning 65, lowering the average age of Medicare beneficiaries and their average health care spending as a group—CBO projects that Medicare spending per beneficiary after adjusting for inflation will grow in the coming decade at an average annual rate of 1.5 percent, compared with an average annual rate of 4

MedPAC, in its March 2014 Report to Congress, continues to call for a permanent fix to the physician fee schedule’s SGR formula, but also calls for flat payments in Medicare for several provider categories.

The state races outcomes, in conjunction with Congressional election results, could be highly material to the future of the ACA. Indeed, the shape of the 2014 mid-term elections could change the candidate pool for and deeply influence the outcome of the 2016 Presidential elections.

percent between 1985 and 2007.

Population Aging Matters Most—Under current law, CBO projects that most federal spending for health care in 2024 will support care for people over age 65—notwithstanding the expansion of subsidies for people under age 65.

CBO projects that, of net federal spending for major health care programs in 2024, about three-fifths will finance care for people over age 65, about one-fifth will finance care for people who are blind or disabled, and the remaining one-fifth will finance care for able-bodied nonelderly people.

In closing, it is important to keep in mind that CBO's estimates, while highly credible, are not dispositive in the sense that they are built on a variety of economic and behavioral assumptions which have proven to be occasionally incorrect. Economic projections are necessary to the functions of government and federal budgetary actions, but are an inexact science and experience periodic updates and revisions in light of actual data, and always in the case of changes in underlying law affecting spending or revenue levels.

Finally, it appears unlikely the Congress will succeed in passing a bi-partisan budget deal under normal budget procedures in the U.S. Congress this session, or at least prior to the mid-term elections. For the same reason, although the President carried out his official part in the fiscal process by submitting his formal budget proposals to the Congress, it receded rapidly from political consideration. It appears more likely that House and Senate leaders will pursue patchwork budget actions to sustain government operations.

II. Politics: The Shadow of the 2014 Mid-Term Elections

Re-Mapping the U.S. Congress—Political leaders and strategists are now singularly focused on November 4, 2014. That is the date of the mid-term general election that will determine which political party will hold the leadership of the House of Representatives and/or Senate of the U.S. Congress for at least the two-year

period leading into the 2016 Presidential election. In fact, the Congressional election calendar is already packed with state-level primaries between now and early summer, as well as select Special Elections to fill certain vacant seats.

In the House, the Republican Party needs to maintain its current Majority position, which most pundits predict it will. In the Senate, the Republicans would need to gain six seats over their current number to secure Majority control. It appears that approximately 11 states are potentially in play for Senate seats making the Senate a major prize opportunity for the Republicans.

As of this writing in spring of 2014, both Democratic and Republican leaders and supporters are reassessing and modifying budget, legislative, public relations messaging, and voter turnout strategies to maximize success in November. Even the President's FY 2015 budget submission to the Congress this spring has been widely characterized as crafted to minimize potential targets against Democratic candidates in the 2014 election cycle. If the Republicans maintain Majority control of the House, and gain Majority control of the Senate, President Obama will face a Congress dominated by a party that has been politically opposed to the ACA since it re-won the House Majority in the 2010 mid-term elections.

Republican Party Perspectives—Since enactment, the ACA has been targeted for repeal, defunding and oversight interventions by Republican leaders. The Republican Party position is that the ACA represents an unwarranted intrusion of government into healthcare, health insurance and employer benefits markets.

Since the 2010 elections, and *as of this writing*, the Republican leaders have yet to craft *and vote* on their own version of the health care reforms, or "replacement plan" they would support if they were to succeed in repealing the ACA. Some ideas have been floated, such as subsidized high-risk pools, small-employer insurance pools, and tax changes, among others. Individual members have proffered

bills. However, there is a large gap to cross from this fragmented state to creating a substantial piece of legislation that gains sufficient party support to allow passage in at least the House of Representatives.

As noted earlier, CBO “scoring” of the costs and benefits of any new piece of health reform legislation modifying the ACA and taken to a House or Senate floor vote provides a critical framework for public understanding of the fiscal and societal implications of federal legislation. Any CBO reports accompanying post-ACA health reform legislation would permit informed debate on what is being undone, as well as done, by new legislation. Failure to take a major vote that puts a political party on record for what it stands for leaves open to voters important questions of how, in this case, the Republican Party would actually (not theoretically) address the access and cost issues in health care that the ACA attempts to address.

The Republican Party must also confront the real impact now of undoing newly secured coverage under the ACA or other popular features in the ACA, such as eliminating the impact of pre-existing conditions as a basis for insurers’ benefit restrictions or premium levels. Finally, as physicians recognize in their practices, there is much more to the ACA than the coverage reforms, central as they are. For instance, how would the Republican Party handle ACA provisions relating to technology adoption, provider payment changes, graduate medical education financing, uncompensated care and other matters? Despite these issues, most Republicans apparently continue to view the persistent “Anti-ObamaCare, all the time” message, as working.

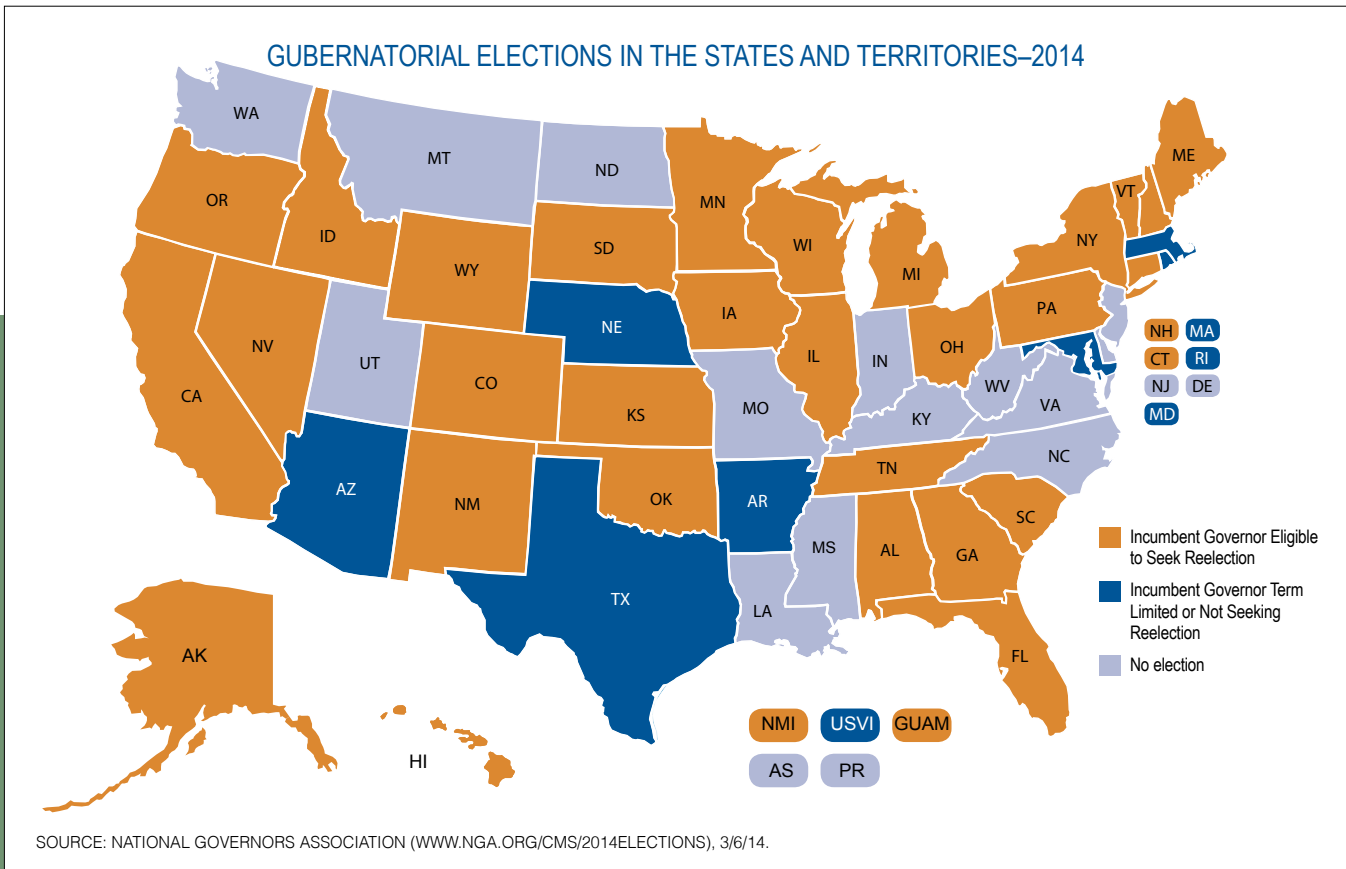
Democratic Party Perspectives—Alternatively, Democrats struggle to craft a more successful formula in their party for educating and persuading more Americans of the overall benefits of the ACA, as well as what they would propose to do to modify any obvious problems in design or execution. There is

a movement among several Democratic Party Senators in the Congress to propose legislation that would modify the ACA to offer more a affordable plan category (copper plans), soften small-employer standards, and include other modifications. From the Democrats perspective, the sustained anti-



ACA effort pursued by Republican and Tea Party representatives has made it not possible to enact a wide array of desirable mid-course legislative modifications to the ACA that the Administration or Congressional Democrats otherwise would have sought. Arguably, because the Republican leaders focused so long on repeal rather than modifications, they forestalled genuine opportunities to address the most problematic issues that could have gained bi-partisan support.

Aside from many benefits, there are also many problematic areas in the ACA, as written; some provisions are poorly conceived or drafted, others are triggering unforeseen or unintended consequences, and some are simply unworkable within the law’s timelines. This is not unusual in complex pieces of legislation. What is unusual is the inability of the Congress to find a reasonable governing pathway to fix problems. These factors may be contributing to the unusual number of delays, alterations and other actions taken by the Administration to address operational challenges and adjust



timelines, despite the law’s wording.

The widespread health insurance exchange website and enrollment problems in the initial coverage rollout became a self-inflicted wound for the Administration and some states, and by extension, to vulnerable Democratic candidates. The complexity makes it hard for the general public to distinguish and properly judge issues in policy from issues in execution. Despite massive outreach efforts, many Americans continue to be poorly informed on the ACA’s major features or view the law negatively (see concluding section below). This adds to the political challenges facing Democrats in the mid-term elections.

Re-Mapping the States: Gubernatorial Elections—The 2014 mid-term elections are major ones for state government, especially for gubernatorial seats. In 2014, elections for Governor’s seats will be held in 36 states (and three territories). The outcomes of these elections could play a material role in national politics post-election, in general, and in state-specific ACA-related actions, specifically.

Above is a graphic of the state gubernatorial races developed by the National Governor’s Association (NGA) in Washington, D.C. We note that nearly every major population center in the U.S. is encompassed within these 36 electoral states. That is material, in part, because many of the most populous states have the largest numbers of uninsured, and/or persons eligible for Medicaid or private health insurance subsidies under the ACA, such as California, New York, Florida and Texas. Separately, we refer interested readers to the *interactive version* of this map on the NGA website, where tapping on a particular state leads to state-level election details (www.nga.org/cms/2014Elections).

Governors, and their state legislatures, have had a material impact on ACA implementation. For instance, a number of Republican-led states declined to take advantage of the ACA’s Medicaid program expansion option, although a few have altered their positions in recent months. Some states enacted laws designed to impede the activities of “navigators” permitted under the ACA to assist citizens in

understanding and enrolling in health plan options under the health insurance exchanges. Alternatively, a number of other states have made large personnel, regulatory and infrastructure investments related to health insurance exchanges. It is unclear what impact the political debate within state races over these varying ACA-related positions and actions will have on the state-level or Congressional races.

Conclusion: The Electoral Fray—Election outcomes for both federal and state races turn on many variables. ACA implementation and public perceptions of the law will play an unclear role (at this stage) in the upcoming campaigns. Election pundits frequently point to the potential impact of the incumbent President’s job approval rating on candidates of the same party. At the moment, according to RealClearPolitics, President Obama’s average job approval is at a relatively low level. The RCP average of several mainstream polls taken during the period of 03/19 – 04/07/14 was 43.0% favorable and 52.8% unfavorable, suggesting there could be a Presidential job approval drag upon Democratic candidates.

Separately, the RCP also routinely tracks and averages the results of several major ongoing polls measuring the public’s approval level of the health care law. For the polling period 03/16 – 04/06/14, the RCP averaged result was 40.1% in favor and 52.4% against or opposed (www.realclearpolitics.com/polls). This is a 12.3% negative spread. Neither of the results is encouraging to Democrats. And, perhaps, they explain the reliance of the Republican Party on the anti-ACA plank as a centerpiece of their electoral efforts in 2014. Public opinion and predicted voter turnout are dynamic as election periods run-up to Election Day, so these and other polling results will be closely tracked right up to election day.

In closing, the state races outcomes, in conjunction with Congressional election results, could be highly material to the future of the ACA. Indeed, the shape of the 2014 mid-term elections could change the candidate pool for and deeply influence the outcome of the 2016 Presidential elections.

III: Assessing the Initial Coverage Rollout—A Rocky Start to the New Era in Health Benefits

Introduction—The very foundations of the ACA coverage rollout were rocked by stunning shortcomings in leadership and technology. There was widespread disbelief that such major management and technology-based enrollment obstacles could occur after nearly three years of federal and state planning, expenditures of hundreds of millions of dollars in federal and state funds, and untold collateral support expenditures in the private health care sector.

These failures occurred in both the federal health insurance exchange operating in half of the states, and in several of the states that elected to set-up and operate their own exchanges. The states of Maryland, Hawaii, Minnesota and Oregon had among the worst problems among states that designed and operated their own exchanges. These exchanges endured to varying degrees the exodus of exchange developers and leaders, the termination of poorly performing contractors, and political fall-out within their states. By the first week of April, Maryland announced it would scrap its exchange in its entirety and substitute Connecticut’s successful exchange model.

Enormous effort and expense went into the design and execution of regulations, policies, management oversight and infrastructure governing all the exchanges. So what happened? Why did it happen? Who was most responsible? And *why does it matter*, given that major, and rapid, mid-course corrections occurred at the federal level and in most of the troubled state launches? The final answers to these questions about the early failures of the ACA’s initial, nationwide open enrollment period will be some time coming. We will discuss key investigatory efforts to uncover them in the next segment. But first, we consider why it matters.

Government Failures Are a Non-Partisan Issue—Regardless of where one resides along the spectrum of preference ranging from smaller to larger roles for government, most would

What domestic policy priority ranked higher in the Administration than the successful implementation of the Affordable Care Act? So what happened? Why did it happen? Who was responsible? And why does it matter?

agree that the laws and related tasks *granted* to government in our democracy should be “faithfully executed.” Implicitly, perhaps ideally, we expect public officials to execute our laws and administer our public programs and resources in an effective, balanced and transparent manner. As taxpayers, citizens have a right to expect that government officials will exercise proper stewardship over public programs and public funds. In particular, the initially inept launch of the federal exchange enrollment website HealthCare.gov, meant to be a signal accomplishment of the Obama Presidency, appeared to fail all these standards, despite the investment of hundreds of millions of dollars and untold hours of human capital.

In fact, stewardship concepts, standards and responsibilities are embodied in a number of laws enacted by the U.S. Congress that directly govern the functions of federal government. These laws set standards for government’s management of fiduciary and operational responsibilities. In the case of HealthCare.gov, failures in information technology (IT) procurement were central. How much that failure was attributable to outmoded procurement rules, and how much was attributable to poor contract procurement and oversight (largely the purview of civil servants), will be parsed over time. For the career Civil Service, it will be just as important to understand failures in needed skills, management and effective political oversight.

The year 2010 not only saw enactment of the ACA, but on January 4, 2011 President Obama signed into law the Government Performance and Results Modernization Act of 2010 (GPRMA), amending the original 1993 GPRA law. Shortly after, on April 14, 2011 Jacob Lew, then the Director of the Office of Management and Budget (OMB, and now the Secretary of the Treasury), released a Memorandum for the Heads of Departments and Agencies outlining how the GPRA Modernization Act affected the federal government’s performance framework and how it related to President Obama’s Accountable Government Initiative.

Particular attention was given to focusing on areas such as human capital, financial management, procurement and acquisition,

and information technology, with requirements to be met by Agencies. These were all *priority areas underlying ACA implementation*, most notably across the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor, acting in coordination with states and insurers. (Note that Jeffrey Zients, later recruited mid-October 2013 by the White House to try to salvage the HealthCare.gov fiasco, co-signed the OMB directive in his earlier role as Deputy Director for Management and Chief Performance Officer). Within this framework of modernization of “Government Performance and Results”, what domestic policy priority ranked higher in the Administration than the successful implementation of the Affordable Care Act?

There are other laws that govern the business performance conduct of federal employees and that guide the acquisition of “mission critical” support services such as contracted expertise or operational capacity not available within an Agency. One example is the Federal Acquisition Regulation; there are others. It is currently unclear whether existing laws were followed, or whether they hindered more than helped in such a large and novel enterprise that demanded special levels of expertise, speed, creativity and genuine management authority. As with so many situations where governance is in question, it may come down to the qualifications and actions of people more than to rules. The ACA’s initial federal marketplace launch on October 1, 2013 appeared to suffer from a lack of truly expert, empowered, and accountable leadership, relative to the requirements of the monumental array of tasks facing the Administration, especially the Department of Health and Human Services, and its subordinate agency, the Centers for Medicare and Medicaid Services (CMS).

We read with interest Time Magazine’s dissection of the emergency efforts to *overcome* the initial rollout failure (“Code Red—Inside the nightmare launch of HealthCare.Gov and the team that figured out how to fix it,” written by Steven Brill and published in Time’s March 10, 2014 issue). Time’s absorbing and detailed report was replete with implications that federal managers were poorly equipped

for this major enterprise; did not know what they did not know at a technological expertise level; and consequently, could not or did not effectively manage competing, non-performing and quarreling IT contractors. In post-October 2013 Congressional hearings, there were representations by contractors that certain policy decisions by CMS complicated their software designs. CMS's own initial enrollment report released on November 13th indicated that a mere 26,794 people, or 10% of the Administration's original projections, had enrolled successfully that first disastrous month.

There is an old idea in public policy to the effect that "regulators" must themselves have skills and expertise that match (or exceed) the skills and expertise of the "regulated." For example, if an official is charged with regulating the private health insurance market, that official should have experience and expertise in that field in order to understand the levers that would be most (or least) effective to apply in meeting public policy objectives. Or, if a major new programmatic responsibility involves complex information technology requiring new software and hardware requirements, personnel with such skills must be recruited and given real authority to carry out an effective contractor acquisition process and to effectively support implementation. In any major government enterprise, the political chain of command at *every level must pay active attention*, ask tough questions and ensure that career staff are truly qualified for and have the resources to carry out the tasks they've been given. As of this writing, it *appears* failures occurred at every level of political and career executive responsibilities, from the White House on down the chain.

A History and Physical on the ACA Coverage Launch—We would suggest that in order for a nation to thrive nationally and globally, it needs to have responsible, transparent and effective government, regardless of size or scope. The U.S. Congress plays an important role in American government by providing oversight of the federal budget and related execution of federal laws and programs. Unfortunately, as we've noted in previous reports in this series, the ACA has become a

particularly polarized political topic. Multiple Congressional Committees have carried out hard-hitting hearings over the last few months investigating concerns Members of Congress have relative to the law's ongoing implementation. However, despite legitimate issues to be investigated, the efficacy of recent Congressional hearings has been arguably undermined by their partisanship and lack of focus on building bi-partisan consensus around practical solutions.



Just as a patient presenting with symptoms to a doctor does, the dissection and correction of ACA implementation problems requires a dispassionate assessment by trained individuals and an efficacious course of action. In the short-run, much of this occurred with the HealthCare.gov website due to the emergency assembly and efforts of dedicated, highly trained individuals largely drawn from high-tech, private sector firms. However, more is required in terms of agency and executive accountability, and in order to discern lessons to reduce the risk of such failures in future enterprises. In addition, the federal government heavily financed the development of states' exchanges under grant awards. The management and IT failures in select states therefore carry federal fiduciary risks that will prompt investigation into accountability and pursuit of remedies.

There are solid entities within government who will conduct such assessments and provide actionable advice to the Congress and the Administration. These are primarily the Government Accountability Office (GAO), an arm of the Congress, and the Office of the Inspector General (OIG) for each of the involved federal agencies. The GAO has already initiated a preliminary investigation into several states' actions. To the extent their missions intersect with the ACA, we also expect the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) to support the efforts of policy-makers. But the latter are not the "watch-dog" agencies over government performance.

We expect the DHHS OIG to conduct a

significant review of the Health Insurance Exchanges—to reveal issues, to consider lessons learned and to identify corrective actions to improve federal (and state) performance. These results will likely not be released until later in 2014, and on some aspects, 2015. We close this section by providing a summary of the DHHS OIG's blueprint for its work on these matters. The subject matter alone is illuminating.

An Editorial Word: The highlights shown on the following opposing pages are heavily redacted from Appendix A accompanying the DHHS OIG's FY 2014 Work Plan, available on the DHHS.gov/OIG website for readers interested in obtaining more information. For instance, the OIG's Work Plan also has other sections on Medicare provider

DHHS OIG Work Plan—FY 2014: Affordable Care Act Reviews

Health Insurance Marketplaces

The Health Insurance Marketplaces (also known as the Affordable Insurance Exchanges or Health Insurance Exchanges) include the Federally-Facilitated Marketplace (FFM or "Federal Marketplace") and State-Based Marketplaces (SBMs). Individuals use the Marketplaces to get information about their health insurance options, be assessed for eligibility (for, among other things, qualified health plans, premium tax credits, and cost sharing reductions), and enroll in the health plan of their choice.

OIG's reviews will focus on ensuring that taxpayer funds are spent for their intended purposes and that Marketplaces operate efficiently and effectively. OIG has prioritized four key areas for FY 2014:

- Payment Accuracy
- Eligibility Systems
- Contracts—Planning, Acquisition, Contracting, Management, and Performance
- Security of Data and Consumer Information

Payment Accuracy

HHS must implement financial management and payment systems to ensure accurate and timely payments to insurers of advance premium tax credits, cost-sharing reduction payments, and premium stabilization payments. Insurers will begin receiving some types of payments in January 2014; other types of payments begin later. Ongoing and planned FY 2014 work that is looking at payment accuracy includes:

- Effectiveness of Internal Controls Over, and Validity of Payments For, Advanced Premium Tax Credits and Cost Sharing Reductions (New)
- Oversight of Risk Corridor Program (New)

Eligibility Systems

The FFM and SBMs must verify consumers' personal information; accurately determine eligibility for qualified health plans, tax credits, and cost-sharing reduction subsidies; and transmit complete, accurate, and timely eligibility information to insurers and consumers. The Marketplaces must also facilitate Medicaid enrollment for those who qualify. OIG's on-going and planned work to ensure the effectiveness and efficiency of eligibility systems includes:

- Review of ACA Enrollment Safeguards (New)
- Health Insurance Marketplaces' Manual Verification Procedures (New)

priorities outside the scope of this report. Our purpose is to highlight selectively the planned work relating to a systematic review of the ACA's challenged coverage rollout. The OIG will also be doing extensive work reviewing the details of state Medicaid expansions and other Medicaid policies, HIPPA privacy rules compliance, and numerous Medicare policies, including the accuracy of physician data on the Physician Compare Website, the integrity of incentive payments for adoption of electronic health records, security of electronic health records and other matters.

We turn next to a snapshot of the overall state-of-play in the ACA's implementation, and emerging issues for 2015.

Contracts—Planning, Acquisition, Contracting, Management, and Performance

Contractors played, and will continue to play, a vital role in building, fixing, and maintaining the systems that underpin the FFM authorized under the Affordable Care Act, § 1321. These systems are critical to the operation of the FFM through HealthCare.gov and to allowing consumers to shop for and purchase affordable health plans. HealthCare.gov is a CMS-managed Web site that hosts the FFM. For FY 2014, OIG plans a comprehensive look at the Department's efforts to implement and operate the FFM. This body of work will include reviews of the planning, acquisition, contracting, contract management, and contractor performance for the FFM. We anticipate covering timeframes both before and after October 1, 2013, including existing and new contracts and contractors. Ongoing and planned work presently includes:

- Implementation of the Federal Marketplace (New)
- Procurement of the Federal Marketplace (New)
- Reporting and Resolution of Problems during the Federal Marketplace Development (New)
- Payments to Federal Marketplace Contractors (New)
- Oversight of Federal Marketplace Contractors (New)

Security of Data and Consumer Information

- CMS's Implementation of Security Controls for the Federally Facilitated Exchange HealthCare.gov (New)
- State-Based Marketplaces Information System Security Controls (New)

Other Programs

- Controls Over Pre-Existing Condition Insurance Plans
- Consumer Operated and Oriented Plan Loan Program—Eligibility Status and Use of Start-Up Solvency loans (New)



Chapter II ►

The ACA: The Changing American Health Care Marketplace

Introduction

The ACA is a complex law introducing complex changes to a complex health care system. Have we said complex often enough? And yet, for ordinary Americans, the ACA has boiled down to the “kitchen table” conversation over how their health insurance choices are changing, what they will cost and whether they can see their current doctor or use the services of a favored health care system, such as for cancer treatment or other medical services. There are echoes in this image of the famous “Harry and Louise” ad mounted in 1993 by the Health Insurance Association of America

(HIAA) to attack President Clinton’s major health reform effort known as the Health Security Act. That ad portrayed a couple’s struggle to understand the complexities of the reform proposal while sitting around their kitchen table. Add a computer terminal to that scene to incorporate today’s website surfing and we appear to be in an eerily similar place 20 years later. Yet, despite the superficial parallels, we are not.

Today, the HIAA is reorganized as America’s Health Insurance Plans (AHIP) and AHIP supported the passage of the Affordable Care Act in 2010. Today’s American family is not speculating anxiously about possible changes to come, but can address concrete questions about the costs and benefits of real plans being made available to them now in a regulated, consumer-choice market. Despite later Congressional involvement, the Health Security Act was initially assembled in part by a diverse working-group overseen by First Lady Hilary Clinton, and whose private deliberations became the subject of litigation over the lack of transparency. That group was informally labeled the “Wall Street Journal 500” after the WSJ secured and published the identities of the participants. By comparison, the ACA was assembled in the more traditional method of lawmaking by Members of Congress in the, at the time, Democratic Majority and their staffs). Numerous hearings were held in the House and Senate Committees of jurisdiction; it was drafted by Congressional legislative counsel, scored by CBO, voted on and enacted into law, albeit with lack of support from the Republican Minority.

Despite the troubled political history of health care reform, our goal in this chapter is a pragmatic one. It is to consider the actual shifts in the health insurance and health care markets that have taken place under the ACA and how they might continue to evolve. We devoted an entire chapter in our preceding report, *From Theory to Boots on the Ground: ACA Critical Issues—Part I*, to the significant changes wrought by the ACA to the way America regulates the private health insurance markets nationwide. We reference this material for those who feel

they would benefit from looking at that report for its detailed background and baseline supporting graphics. We provided summary “baseline” information on:

Exchanges, Federal or State—Functions and oversight of health insurance exchanges (regulated marketplaces to permit the offering, comparison and purchase of qualified health plans), federal and state roles, plus options for states to operate their own exchanges or default to the federal exchange (HealthCare.gov),

Federal Oversight—Major new federal authorities that are preemptive of state governments traditional roles in regulation of health insurers,

Health Plan Requirements—Financial, plan benefit design, and consumer protection obligations of health plans (including provider network adequacy) participating in the exchanges,

Navigators—Roles and responsibilities of “navigators” to assist consumers in understanding their health plan choices and obligations,

Individual Obligations—Shared responsibility obligations for individuals related to the requirement to carry coverage (aka, the individual mandate and penalties for failure to secure qualified health insurance coverage), as well as the availability of tax credits and subsidies,

Employer Obligations—General employer obligations, and the small-employer health options plan (SHOP),

Medicaid Expansion Option for States—Medicaid program changes, expanded eligibility and federal financing options, and states’ initial decisions as to whether to make those options available within their state, and

Critical Information Technology (IT)—Crucial role of IT in creating and supporting the federal and state exchanges, related websites and data processing, plus the new federal “Data Hub” (graphic provided) required to exchange continuously high volumes of information among multiple federal agencies and health plans.

We proceed by providing select status updates and then conclude this chapter by discussing critical challenges to the ACA, and perspectives on how the health care insurance market could evolve.

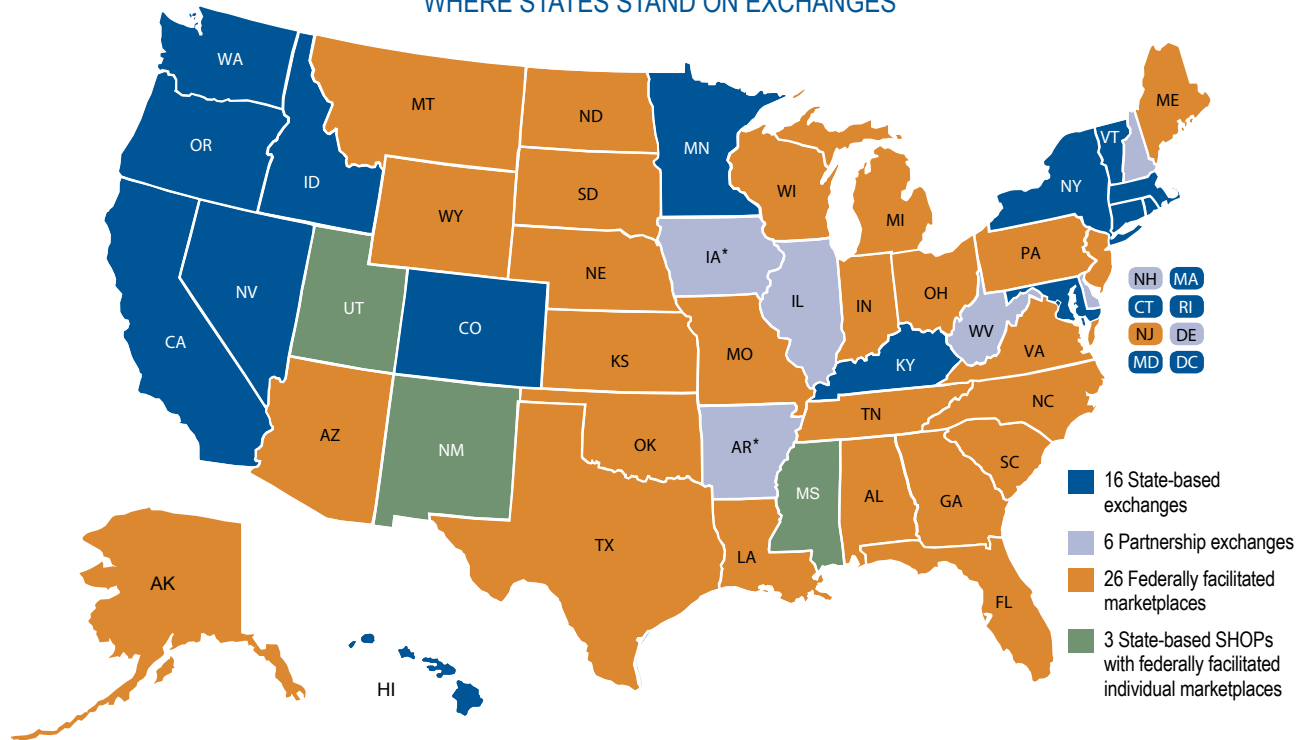
I. A Snapshot of the October 2013 to March 2014 ACA Coverage Rollout

On October 1, 2013, qualified health plans were offered in all 50 states and the District of Columbia, under different exchange models. To recap (in abbreviated form) the preceding report cited above, there are four basic exchange models:

- State-Based Exchange (SBE), under state management
- State Partnership Exchange (SPE), which shares tasks with the federal government, but is considered a subset of the federally-facilitated marketplace
- Federally-Facilitated Marketplace (FFM), operated under federal management through the portal of HealthCare.gov and *only 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)
- Small Business Health Option (SHOP) exchange, targeted to the small-group market and which can be under federal or state management.

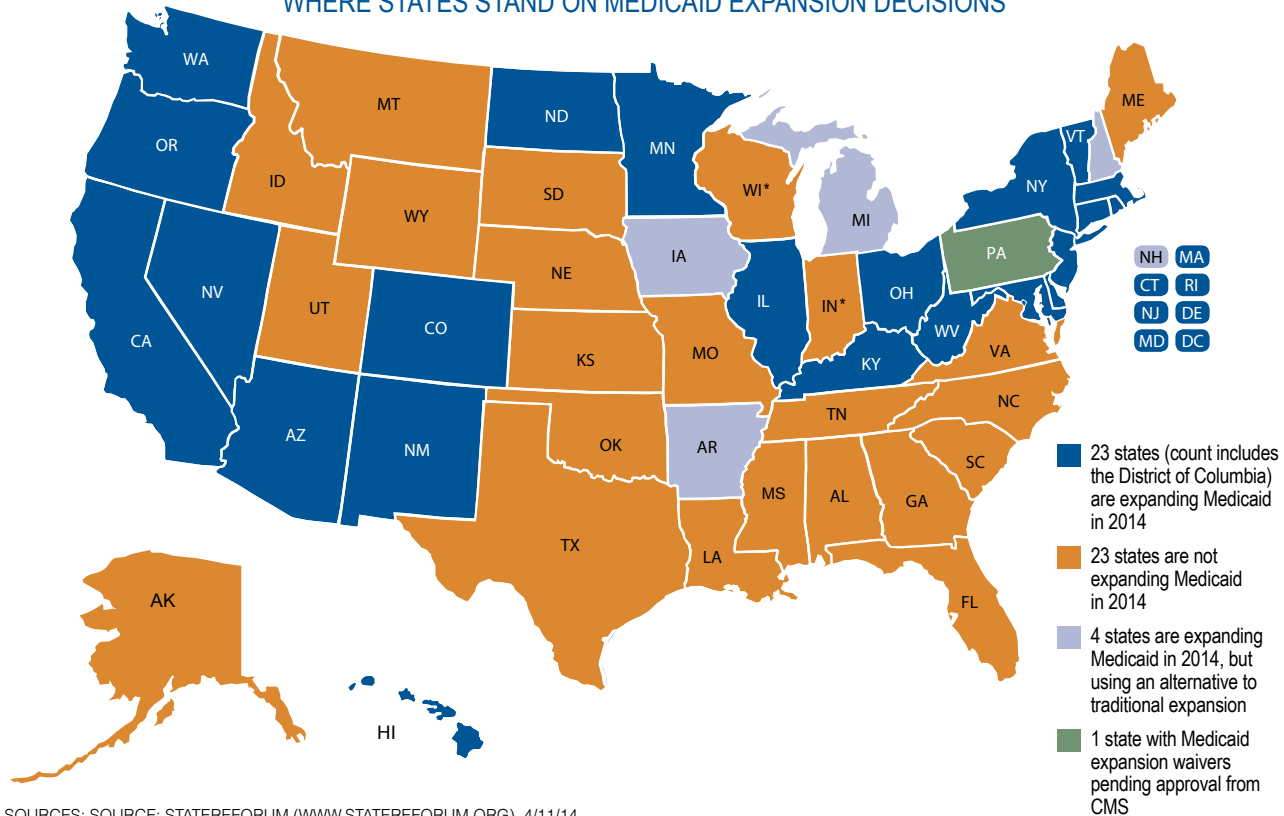
Entering the open enrollment period, which ran from October 1, 2013 through March 31, 2014, 15 states and the District of Columbia operated their own individual exchanges. In the remaining states (35), the federal government operated the federal exchange, although 15 of the states in this group assisted with some tasks, to varying degrees. Following is a state map breakout of the exchanges as of March 2014.

WHERE STATES STAND ON EXCHANGES



SOURCES: SOURCE: STATEREFORM (WWW.STATEREFORM.ORG), 3/11/14.

WHERE STATES STAND ON MEDICAID EXPANSION DECISIONS



SOURCES: SOURCE: STATEREFORM (WWW.STATEREFORM.ORG), 4/11/14.

II. Medicaid Expansion

The ACA's Medicaid expansion was originally construed by the Administration as mandatory upon states. As described in our preceding report, this issue was litigated and ruled upon by the U. S. Supreme Court in a multi-faceted ruling on ACA issues. The Court found that it is *optional* for states to expand their Medicaid programs. Nearly half of the states (all predominantly Republican-led) chose not to expand their programs despite the availability of 100% federal financing for the first three years, and gradual decreases thereafter until the level reaches 90% federal financing in 2020, where it remains unless the law is amended.

Efforts have been underway in a handful of the original non-expansion states to reconsider their original decision or to seek expansion by pursuing non-traditional coverage paradigms, working with the federal government to obtain approval. In other words, this is a continuing and important issue with respect to the coverage goals of the ACA, especially with respect to reaching and financing services for lower income, poorer health status populations. As an important reminder, the Supreme Court's decision that the Medicaid expansion was at States' option, created a coverage support anomaly. Individuals between 100-138% of the federal poverty level, intended under the law to be covered by Medicaid, are not in the non-expansion states, but are also not eligible for federal insurance subsidies, as illustrated here.

Medicaid expansion is a dynamic issue in many states and will likely be debated in many of the races in the 2014 mid-term state-level elections. Opposite is a graphic that shows the current status of state positions on the expansion option.

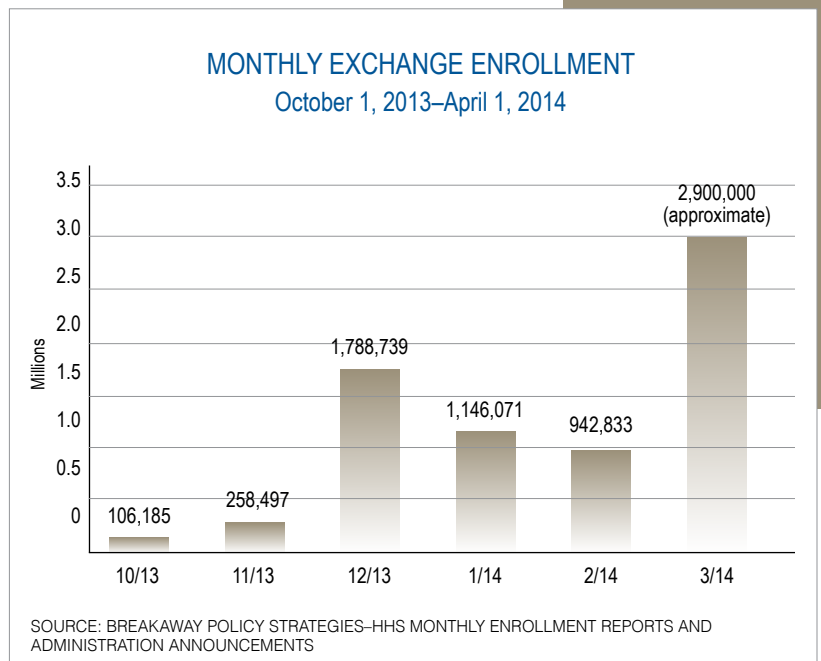
Separately, as we go to press, DHHS reported in April that 3 million individuals were enrolled in the state Medicaid programs. This figure does not differentiate between those enrolled in previously existing programs and those enrolled in newly expanded programs. This figure will be updated with greater accuracy over time as states correct, update and file their quarterly enrollment reports.

III. Enrollment Tabulations

Officially, the initial ACA open enrollment period ran from October 1, 2013 to March 31, 2014. It will never be known for certain what enrollment suppressing impact the early exchange failures had on this first open enrollment season.

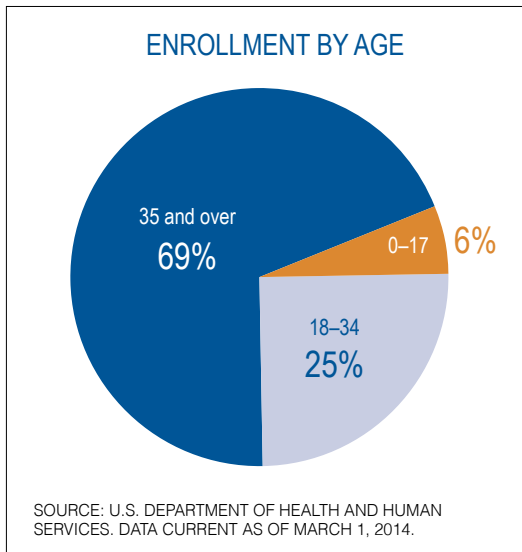
Preliminary Enrollment Levels—As of March 31, 2014, the federal Department of Health and Human Services reported enrollment of over 7 million people. Preliminary enrollment is defined as the number of individuals who have selected a plan through a state or federal exchange (aka marketplace). Some states and the federal government have provided a little leeway beyond March 31 for applicants who initiated their plan selection but may have not quite completed it due to exchange-related enrollment delays.

Final Enrollment Levels—These will not be determined until some time after the close of the period due to exchange and insurer processing requirements and delays, and because *individuals' enrollments are not finalized until they have paid the first month's premium* to their chosen health plan. The following enrollment timeline tells the tale of the troubled rollout's first month.



Despite a rocky start, CBO estimates nearly a four-fold increase in ACA enrollment through exchanges in only three years.

Enrollment Composition—Other important parameters relate to the relative age composition of enrollees. The ACA imposed new premium rating rules and constraints on qualified insurers participating in the exchanges. These were to reduce issues of market segmentation by health risk or experience rating. The practical effect is to require greater premium averaging or cross-subsidization across age groups. This means that, *on average*, a younger, healthier person who costs less pays more than they otherwise might have, and a less healthy, older person who costs more pays less than they otherwise might have. It is important for average premium levels and stability over time that sufficient numbers of younger and healthier persons enroll to offset the higher average claims cost of older and less healthy enrollees. Following is information on the breakdown to date of preliminary enrollment by age cohorts.



Enrollees Eligible for Subsidies—There are detailed subsidies available for individuals and families under the ACA. Understandably, these add a layer of unfamiliarity to the plan selection and enrollment process. Early reports from the field suggested that informing target populations about the availability and levels of the subsidies has been a particular public education challenge. Following is a chart summarizing the requirements.

Income-related subsidies under the ACA

are a major cost of the law going forward. Total subsidy spending will be determined by factors such as total enrollment, income levels of enrollees, subsidy generosity level, and premium costs of selected plans. To date, over 60% of enrollees have chosen the Silver plan – a model which pays about 70% of the average, actuarial value of the benefit. On March 25, 2014, CBO sent a letter to House Budget Committee Chairman Paul Ryan depicting its estimates of federal spending for the government’s major mandatory spending programs and those that are primarily means-tested, such as tax credits for assistance in securing ACA-based health insurance coverage (we discuss legal challenges to the provision of tax credits in federal exchanges in the next section). In relevant part, CBO stated:

“Payments of health insurance subsidies under the ACA began in January 2014, and the high rates of growth projected for the next several years reflect a start-up period for the new program. In the current projection, the number of people gaining coverage through the exchanges rises from 6 million in 2014 to 22 million in 2016. CBO projects that, after the initial start-up, annual growth will average about 6 percent over the 2018-2024 period.”

CBO estimated that outlays for health insurance subsidies would cost \$15 billion in 2014, and rise to \$143 billion in 2024, for an average annual growth rate of 24.9% over the period of 2015-2024. Despite a rocky start, CBO estimates nearly a four-fold increase in ACA enrollment through exchanges in only three years. With this basic snapshot, we turn to major challenges facing the ACA and the potential evolution of the health insurance market in the U.S. Opposite is the chart depicting the subsidies framework.

IV. Critical Challenges to the ACA

The major challenges to the ACA are political, structural, and operational. In our preceding report, we highlighted the following:

- 1 ➤ Sustained political opposition by conservatives at federal levels, which has been manifested through Republican and Tea

Party sponsored ACA repeal, defunding, critical oversight, and media messaging efforts.

- 2 > Sustained, but with some exceptions, political opposition in Republican-led statehouses and legislatures leading to an unexpected and large number of states defaulting to the federal exchange and/or declining to expand their state Medicaid programs.
- 3 > Legal challenges regarding a) the shared responsibility payment (individual mandate), b) the optional character for states of the Medicaid expansion provisions, c) the employer provision of contraceptives coverage, and d) the availability of tax credit subsidies to individuals who enroll in health plans through the federal, as opposed to state exchanges.
- 4 > Extensive new demands on federal and state governments to operationalize the requirements of the law impacting upon personnel, budgets and straining

operational capacities. We particularly highlighted the initial technological challenges in operationalizing the federally facilitated exchange, including its critical data hub.

- 5 > Extensive structural issues in the law, as passed, leading the Administration to recommend and the Congress to repeal the Community Living Assistance Services and Supports (CLASS Act), as well as leading to a number of regulatory and executive actions by the Administration to delay certain provisions.
- 6 > Physician-specific challenges related to risks associated with health plan “network adequacy” requirements. (Note: See Chapter III. The ACA contains numerous other provisions of concern to physicians. Many were discussed in earlier reports, and a number will be explored in depth in our upcoming report examining the Medicare program as an instrument of reform under the ACA).

These challenges continue largely unabated,

PREMIUM TAX CREDITS AND COST-SHARING PROTECTIONS UNDER THE AFFORDABLE CARE ACT

FPL	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: if in Silver plan
<100%	S: <\$11,490 F: <\$23,550	0% (Medicaid)	0% (Medicaid)	100% (Medicaid)
100% – 132%	S: <\$11,490 – <\$15,282 F: <\$23,550 – <\$31,322	2%, or 0% if Medicaid	S: \$2,250 F: \$4,500	94%
133% – 149%	S: <\$15,282 – <\$17,235 F: <\$31,322 – <\$35,325	3.0% – 4.0%		94%
150% – 199%	S: <\$17,235 – <\$22,980 F: <\$35,325 – <\$47,100	4.0% – 6.3%	S: \$5,200 F: \$10,400	87%
200% – 249%	S: <\$22,980 – <\$28,725 F: <\$47,100 – <\$58,875	6.3% – 8.05%		73%
250% – 299%	S: <\$28,725 – <\$34,470 F: <\$58,875 – <\$70,650	8.05% – 9.5%		70%
300% – 399%	S: <\$34,470 – <\$45,960 F: <\$70,650 – <\$94,200	9.5%	S: \$6,350 F: \$12,700	70%
400%+	S: \$45,960+ F: \$94,200+	–		–

Four levels of cost-sharing: Bronze: actuarial value 60% Silver: actuarial value 70% Gold: actuarial value 80% Platinum: actuarial value 90%

Note: FPL refers to federal poverty level as of 2013. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan. Out-of-pocket limits for 2014.

SOURCE: COMMONWEALTH FUND HEALTH REFORM RESOURCE CENTER: WHAT'S IN THE AFFORDABLE CARE ACT? (PL 111-148 AND 111-152), WWW.COMMONWEALTHFUND.ORG/HEALTH-REFORM/HEALTH-REFORM-RESOURCE.ASPX.



with just a few updates and exceptions discussed below.

Political Opposition—The sustained political opposition by many conservatives to the ACA’s development, enactment and implementation has continued unabated into its fifth year (2009-2014). At the federal level, the intensity, tone and strategies of the opposition preclude traditional legislative discourse on the future of the law, or post-enactment (bipartisan) efforts within the Congress to address the law’s shortcomings. As of this writing, even some Democrats are opening discussions on what changes they think are desirable to make to the original law. As we’ve noted elsewhere, there are numerous adjustments that could and should be considered in a bipartisan manner by the Congress.

The picture is a little more mixed at the state level. Opposition to ACA-based shared

governance and programmatic changes appears to remain strong in a number of mainly southern and western states. Other Republican-led states, however, have taken steps to assist on exchange tasks even while defaulting to the federal exchange, and a few others have modified their original positions on Medicaid expansion, with some agreements for programmatic innovations negotiated with the federal Department of Health and Human Services. It may take the 2014 mid-term elections *and* the 2016 Presidential election to adjust the political landscape sufficiently to clarify the future direction of the law.

Legal Challenges—Of the four legal challenges highlighted above, the first two were addressed by a Supreme Court decision delivered in June 2012. The Court upheld the *individual mandate*, while ruling that the *Medicaid expansion* provisions were not mandatory upon, but optional for the states.

➤ **Contraceptive Benefits**—Separately, on March 25, 2014, the Supreme Court heard arguments over whether employers can opt-out of the benefit package mandate that requires them to offer *contraceptive coverage* in their employee health plans on the basis of the religious objections of the company’s founders/managers. The plaintiffs are Hobby Lobby Stores and Conestoga Wood Specialties; both are for-profit companies. These cases raise issues under the First Amendment’s free exercise of religion clause and the 1993 Religious Freedom Restoration Act, which states that, “government shall not substantially burden a person’s exercise of religion.” Issues revolve around concepts of whether corporations are a “person” that can exercise religious belief in this context, whether the government has a “compelling interest”, and whether firms would not be substantially burdened by compliance with the regulations. A ruling will come later in the Court’s term.

➤ **Availability of Subsidies in Federal Exchanges**—Separately, a potentially much more serious challenge to the law’s fundamental structure and benefits is still winding its way through the federal court system. This is a case whose basic legal premise, based on a strict reading of the law’s words, rather than on broader evidence of its intent, was initially

highlighted by the Cato Institute. The complaint was brought by plaintiffs in the case *Halbig v. Sebelius*, against an Internal Revenue Service (IRS) interpretive rule of the law. The IRS rule makes subsidies available to individuals that reside in all states, including in those that default to the federal exchanges. Appellants argue that the law refers only to *state exchanges* in its *eligibility rules governing subsidies*, and in strict wording, fails to specify that individuals in states covered by the federal exchange are eligible for subsidies. The government offered several arguments in favor of the broader, uniform effect interpretation. This case was argued in the federal D.C. Court of Appeals (one level below the U.S. Supreme Court) on March 25, 2014.

The implications of this legal dispute for the law are profound. A decision adverse to the government's interpretation jeopardizes several billions of dollars in subsidies already payable to insurers on behalf of a few million individuals now enrolled in states that defaulted to the federal exchange, could wreak financial hardship and premium payment defaults by many financially stretched enrollees, and could be very damaging to the insurance markets in those states. This is not the only case winding through the federal courts and challenging this IRS interpretation of the ACA, as drafted (perhaps its most serious drafting issue). The cases challenging the legal availability of subsidies for residents of states covered by the federal exchange are a major "watch-out under the law."

Operational and Technology Challenges—As we discussed earlier in this report, the GAO and the DHHS Inspector General are already launching significant investigations into the management, fiscal, and technology procurement issues behind operational failures in the federal and several of the state exchanges. These investigations could have material implications for select executives and contractors, federal and state. Since large sums of federal funding are involved in the state exchanges, other laws and penalties could come into play. The results of these investigations will not be available until later in 2014, and perhaps even in 2015.

Concerning the federal exchange, a quite

successful technological intervention was carried out last fall to address the major impediments to front-end enrollments through HealthCare.gov. However, work continues on serious "back-end" problems addressing delayed processing of Medicaid applications, communications and fiscal interactions with private insurers and other critical, albeit "nuts-and-bolts" matters. These issues could persist for months.

Separately, the Administration, especially at DHHS, carries a large, ongoing responsibility for finalizing ACA-related regulations in multiple areas. Simultaneously, work is underway to finalize 2014 enrollments, while preparing for the 2015 open enrollment period. The latter necessitated a significant set of policy reviews, guidance materials and adjustments for insurers, as well as states. It is an open question as to how well these tasks can be or are being carried out, and whether the responsible agencies, such as the Centers for Medicare and Medicaid Services, have the appropriate personnel and resources given the federal budget issues and Congressional de-funding efforts. These questions apply as well for the IRS, in managing subsidies and other related matters, and for the Department of Labor, managing employer and employee health benefit issues and interactions.

Other Operational Issues: Executive Actions—Among the many controversies for Republicans with respect to the law are the executive actions taken by the Administration to extend deadlines, delay implementation of some provisions, and otherwise modify the statutorily prescribed implementation of the ACA. The Republicans assert they are for political ends; the Administration asserts they are for compelling operational reasons.

Private insurers, largely silent until recently, are reportedly beginning to complain about the disruption of mid-stream rules changes, delays in deadlines, and reversals in policy. One example of the latter was a mid-open enrollment period decision to permit individuals in non-compliant plans to remain in such plans for up to two years, provided their state regulators and their insurer agreed. This was to quell a groundswell of complaints about

On March 25, 2014, the Supreme Court heard arguments over whether employers can opt-out of the benefit package mandate that requires them to offer *contraceptive coverage* in their employee health plans on the basis of religious objections.

True success of the ACA coverage goals will ultimately depend on broader public support and permanent integration into our societal fabric.

compelling previously insured individuals to switch into ACA-based plans. The latter were more expensive in some cases due to new minimum benefit requirements.

On March 26, 2014 Politico published an article titled “A Brief History of Obamacare Delays.” It identified no less than 10 delays in deadlines. These included multiple delays of employer mandates, delay of the 2015 open enrollment period by one month, delay of online enrollment for SHOP, two extensions for high-risk pools, and extensions for enrollment. The latter includes a short grace period after the March 31, 2014 open enrollment period deadline for people experiencing special circumstances in completing applications *initiated by March 31*. While these may contravene the strict wording of the law, in a more hospitable political climate such actions would likely have aroused less ire. Or, the Congress could have acted on a set of legislative adjustments to resolve or offset the negative impact upon individuals of implementation problems and unrealistic deadlines.

Conclusion—The future of the access, affordability and coverage provisions of the ACA relies upon a complex stew of:

- national and state politics,
- the outcomes of multiple legal challenges,
- the continued expansion of Medicaid across states that initially chose not to do so, perhaps coupled with Medicaid programmatic reforms,
- improved management, oversight and information technology support of federal and state exchanges,
- improved educational outreach and navigational support to citizens who can benefit from new coverage opportunities, and eventually,
- bipartisan Congressional and Administration action on a legislative package designed to simplify and improve the original law (full repeal is unlikely in the near term).

In the meantime, there are essential metrics by which to evaluate interim progress toward these goals, as definitive data become available. These relate to the open enrollment period

just closed, to the dynamics on Medicaid expansion, and to the exchange and health insurers’ dynamics entering the *shorter* 2015 open enrollment period currently scheduled for November 15, 2014 to February 15, 2015.

Such metrics create an essential baseline by which to evaluate the impact of the ACA in its first full open enrollment period, but even more importantly, to assess both rapid and longer-term effects. For instance, exchanges need first year enrollment figures across plans and individual products to assess consumer preferences regarding price and coverage trade-offs in the marketplace. Exchanges need to be able to evaluate the upcoming round of insurer offerings, including premiums and costsharing, among other requirements, prior to entry into the 2015 enrollment period. The window for plan submissions and exchange approval is narrow.

Important metrics include, but are not limited to:

TOTAL ENROLLMENT—What are the final enrollment figures (after individuals’ enrollments are affirmed by first month premium payments)?

ENROLLMENT: SLICED AND DICED—What is the risk pool experienced by insurers, i.e., the age distribution, subsidy status, health status, and early medical claims experience of enrollees? How many new enrollees were previously uninsured, or (much harder to tease out) underinsured? What other enrollee characteristics need to be understood, such as primary language, rural versus urban location, etc.?

STATES AS LABORATORIES—What are the major results and variations across states? What lessons are there for future policy or operational actions, both in Medicaid and in private health insurance plan markets?

Each state presents its own microcosm of politics, health insurance market regulation, exchange management and participation, information technology and infrastructure success, eligible populations, qualified health plan participation, navigator rules, rates of uninsured, and income distributions and employment levels. In effect, each state has become an ACA laboratory, and the results

across states in the first year appear to be highly variable. These variations need to be understood and acted upon, as needed.

MAJOR INSURER RESULTS—Participation results, plans offered vs. plans purchased, enrollee composition and early experiences across products, provider network adequacy issues, financial investment and early results, and the plans' decisions on offerings for 2015. How do those offerings compare to their 2014 portfolio of product offerings? Any major withdrawals of plans in select markets entering into 2015? Why? What implications for long-term stability for federal and state policy, if any?

STATE V. FEDERAL EXCHANGES IN 2015—Will there be major exchange model shifts in 2015? Will more states default to the federal government? Or will the reverse happen, i.e., will some states that initially defaulted to the federal exchange step-up to operate a partnership model or fully functional state exchange in 2015 or 2016? Will more states adopt another state's more successful exchange technology, as Maryland is doing with Connecticut's?

From a health care reform and health care professional's perspective, the adventure is just beginning. There is so much more to consider that, regrettably, is outside the scope of this report. For instance, what will be the effects of the ACA's coverage and access provisions on prevention and other categories of medical services utilization, on rural and frontier area services, and on services to special populations? These are important and interesting questions to investigate over time. In closing, we now turn to an area central to the mission of the Physicians Foundation. That is, review of current, key developments for physicians in private medical practice.

What will be the effects of the ACA's coverage and access provisions on prevention and other categories of medical services utilization, on rural and frontier area services, and on services to special populations?



Chapter III

Select Issues for Physicians in Private Medical Practice

Introduction

At this stage in implementation of the ACA, coverage expansion and access to insurance coverage are temporarily ascendant in the public arena. Meanwhile, deeper transformational changes fostered by other ACA provisions affecting health care organization, delivery and metrics are also underway. Examples include provider payment reforms, adoption of electronic health records, introduction of systematic quality measures into health services, provider profiling, and new health service delivery organizational models, such as Accountable Care Organizations (ACOs).

Health care delivery is being reshaped in the United States by health care systems and providers seeking business efficiency and profitability, as well. These, plus ACA drivers, affect trends toward greater hospital system consolidation, a growing pre-dominance of for-profit ownership in sectors other than hospitals, and a generational shift in physician

practice models. As we've noted before, there are increasing numbers of physicians exiting (or never entering) solo, private medical practice. Instead, the trends are favoring group models, employment by hospitals or other systems, or shared practice configurations such as the rapidly growing ACO models.

Physicians are navigating issues in the broad ACA coverage rollout, and important practice issues prompted by separate ACA provisions effected through the Medicare program. Some of these areas are also impacted upon by newly enacted legislation changing the Medicare fee schedule and other policies affecting Medicare providers.

For purposes of this report, we highlight issues for practicing physicians drawn from both spheres: the ACA coverage effort, and immediate Medicare issues. In the ACA coverage sphere, we follow-up on the adequacy of provider networks of health plans participating in the exchanges. We had highlighted this as a

“Watch-Out” issue in our preceding report, and there are important new federal and state oversight developments.

With respect to Medicare, we examine physician payment and other highlights from the March 2014 Report to Congress released by the Medicare Payment Advisory Commission. Separately, we summarize select new legislative provisions, just enacted into law under the Protecting Access to Medicare Act of 2014, as they affect physicians and certain other providers’ policies. We turn first to the issue of network adequacy requirements for qualified health plans.

I. Network Adequacy: A Critical Component of ACA Coverage Success

Health Plan Perspectives—Even preceding the advent of private health insurance exchanges under the ACA, there was a dynamic tension between physicians, hospitals, other health care providers and health plans over the terms under which all health care providers “support” private insurer’s plan offerings. From the plans’ perspective, their provider networks need to be sufficient to attract enrollees and meet their contracted-for health benefit coverage. However, plans also seek to balance provider network size and costs with a market imperative for competitive premiums and profitability, in part through managing network size, composition, and payment-for-services costs. Aggregate claims costs are derived from health characteristics of enrollees, utilization of services (including questions of medical necessity and coverage), and liability for payments for services negotiated with providers. Variations on these dynamics exist in the individual, small-group and large-group markets, including self-funded employer health benefit plans.

Physician Contracting Challenges—From physicians’ perspectives, health plan contracting can be a very challenging and unavoidable business aspect of practicing medicine in a diverse, private health insurance environment. Contractual agreements with insurers are encircled by anti-trust strictures, confidentiality agreements,

breach-of-contract clauses, and various penalties. In addition, some insurer contracts may have automatic participation clauses wherein a physician agrees to participate automatically in other products from the same insurer. Sometimes insurers initiate new products, add physicians to the supporting networks, without necessarily informing the affected physicians. To further complicate these scenarios, there can be payment (rate) variations for services across different plans offered by the same insurer.

ACA “Network Adequacy” First-Year Issues—In general, under the first open enrollment period of the ACA, relatively little attention was given by regulators in some states as to how well the initial round of qualified health plans met the general standard of ensuring “network adequacy” in supporting their plans. Issues were raised in several states and locales when enrollees could not determine which providers were supporting plans during the enrollment process. Some enrollees joined a plan only to learn that their personal physician or preferred hospital system was not included in their chosen plan. Some physicians were equally unclear as to whether they had been included in certain plans and under what terms. Or, given the accelerated schedules for the ACA rollout, contract terms offered by some plans were less than ideal, yet some physicians felt they had little choice but to participate under those less than ideal conditions. Others chose not to participate. In short, confusion reigned.

As plan network complaints surfaced and grew, a number of state regulators and federal officials took note. Even while the 2014 open enrollment was underway, federal officials formulated proposed regulatory changes and issued more elaborate guidance on what the term “network adequacy” means. These policies are described at some length in the recently released federal guidance notices (proposed and final) setting minimum standards that health plans must meet in order to qualify for participation in the state and federal exchanges in the 2015 open enrollment period beginning on November 15, 2014. Following is a synopsis of the 2015 standards issued to health plan applicants.

Qualified Health Plan (QHP) Oversight—First, it is important to understand government

Under the ACA, states continue to be the primary regulators of health insurers and are responsible for enforcing the market reform provisions in Title XXVII of the Public Health Service (PHS) Act, both inside and outside the Marketplaces.

If a state “fails to enact legislation to enforce, or is otherwise not enforcing” the ACA’s market and health plan requirements, or if CMS determines a state is not “substantially enforcing” the requirements, CMS is responsible for enforcing them.

oversight responsibilities between the federal government and states with respect to ensuring health plans meet ACA-based requirements, including for network adequacy. On March 14, 2014, CMS’s Center for Consumer Information and Insurance Oversight (CCIIO) issued its finalized “2015 Letter to Issuers in the Federally-facilitated Marketplaces,” or FFMs. This guidance, supplemented by regulations and other releases, finalizes an array of policies and standards governing health plans, a number of which apply both inside and outside of exchange marketplaces. Any page references given below are for this document.

CMS takes care to highlight that, under the ACA, *states continue to be the primary regulators of health insurers* and are responsible for enforcing the market reform provisions in Title XXVII of the Public Health Service (PHS) Act, *both inside and outside the Marketplaces* (p. 6). Some states have higher standards in some areas. However, if a state “fails to enact legislation to enforce, or is otherwise not enforcing” the ACA’s market and health plan requirements, or if CMS determines a state is not “substantially enforcing” the requirements, CMS is responsible for enforcing them.

Under ACA implementing regulations (45 C.F.R. 156.230(a)(2)), the issuer of a qualified health plan, or QHP, that has a provider network, must meet sufficiency requirements, including for mental health and substance abuse services, and attest in writing that they are met for recertification for 2015. Unlike in 2014, CMS will assess provider networks using a “reasonable access” standard and will identify networks that fail to provide reasonable access without unreasonable delays (p.18). CMS states it will focus most closely on those areas that have historically raised network adequacy concerns. These may include:

- 1 > Hospital systems,
- 2 > Primary care providers,
- 3 > Oncology providers, and
- 4 > Mental health providers.

Other important guidance:

- 1 > CMS will engage with plans before addressing recertification risk,

- 2 > CMS will share and coordinate analyses with states,
- 3 > CMS will consider lessons learned via interactions to possibly develop time and distance, or other network adequacy standards, in future rulemaking, and
- 4 > CMS is considering developing network adequacy complaint tracking capabilities, and formats for provider network data collection in the future, the latter of which could allow for the future creation of a provider search engine function on HealthCare.gov.

Multi-State Health Plan (MSP) Oversight—

The ACA also provides for the MSP program which permits a single issuer to offer plans within exchanges across multiple states. The MSP program is administered by the federal Office of Personnel Management (OPM), in collaboration with state regulators. OPM is located in Washington, DC. The principal office for this function within OPM is the Office of Healthcare and Insurance, headed by John O’Brien, Director.

OPM has decades of experience in setting standards and certifying plans for participation in the Federal Employees Health Benefit Program, which has functioned for years much like an exchange. That is, qualified local and multi-state plans participate in an annual open enrollment period and compete for enrollment among the civilian federal employee population. Federal employees shop on-line for plans, compare benefits, provider networks, and costs, and enroll via a secure website.

Under the ACA, for the 2014 open enrollment period, OPM certified over 150 MSPs covering 30 states and the District of Columbia. OPM released its 2015 MSP Program Issuer Letter on February 4, 2014. It set standards MSPs must meet for certification to participate for the contract term beginning January 1, 2015. OPM focused on four key areas, discussing each in detail:

- 1 > Benefit design
- 2 > Wellness
- 3 > Network standards
- 4 > Quality of care

Under network standards, OPM emphasized the following, stating MSPs must ensure that:

- 1 > Networks have sufficient numbers and types of providers to meet the needs of a diverse population,
- 2 > Networks are monitored continuously for quality and access,
- 3 > Network services (provider and pharmacy) are accessible without unreasonable delay,
- 4 > Networks include a sufficient number of essential community providers and retail pharmacies that serve predominantly low-income, medically-underserved individuals,
- 5 > Network adjustments are made promptly when needed,
- 6 > Timely processes are in place to ensure that consumers who need care from out-of-network providers (for rare or complex medical conditions, or lack of in-network providers) receive such care with reasonable cost-sharing, and
- 7 > Issuers must provide consumers with ready access to clear and accurate provider directories, both before and after they are enrolled.

Finally, OPM stated, as did CMS, that it will give special attention to areas where concerns about network adequacy have been raised.

Conclusion—In closing, network adequacy requirements fall within a multi-level enforcement paradigm. This generally means that providers or individuals with network-related concerns should first determine whether their state insurance regulators or other designated officials are taking responsibility for enforcing the standards, before filing federal complaints. Even in federal exchange states, on some matters, state officials may be taking the lead or assisting on some tasks. The correct front-line on enforcement needs to be determined in such circumstances.

Separately, CMS and OPM communicate on plan standards, most of which are comparable, but they also clearly diverge in some ways. Regardless, issues over qualified health plans should be directed to states and/or CMS, and issues over the network adequacy conduct of a multi-state plan should be directed to states and/or OPM. We highly recommend that physicians consult with their state medical societies on such matters, as well.

II. Medicare Matters

In the midst of temporary ACA coverage ascendency in the public sphere, the Medicare program continues to grow in size, societal impact and as a tool for government intervention in the health care system. As noted earlier, the Physicians Foundation will soon release a report that focuses entirely on the Medicare program. We will examine the extensive means by which ACA-based and other policies pursued through Medicare’s massive purchasing power seek to actively reshape cost and quality in the American health care system.

In this report, we limit our Medicare review to reporting on select Medicare highlights just released by the Medicare Payment Advisory Commission (MedPAC), and to the legislation enacted on April 1, 2014 that temporarily “patches” the Medicare physician fee schedule update mechanism, and adjusts other policies.

Report to the Congress on Medicare Payment Policy—Late in March, MedPAC released the cited annual report to the Congress. Its 401 pages are packed with data, views and recommendations on the Medicare program. The report serves as a primary source document on the program for lawmakers, their staff and others interested in Medicare public policy.

A few framing statistics are useful before discussing select physician findings. MedPAC reports the following statistics drawn from data compiled by CMS for National Health Expenditures, 2012:

- > Total health spending in the U.S. in 2012 equaled \$2.4 trillion.
- > Medicare constituted 23% of that total (or \$574 billion), second only to private health insurance at 34%. Medicare is the largest single purchaser of personal health care in the U.S.
- > Of the \$574 billion, spending for the top three categories were: hospitals (inpatient and outpatient services) at \$179B, Medicare Advantage at \$136B, and the physician fee schedule at \$70B.
- > Citing CBO, MedPAC reports that general revenue transfers to Medicare accounts for 40 percent of Medicare’s total revenues, and

Medicare is the largest single purchaser of personal health care in the U.S. Payments to physicians under the fee schedule were \$70B in 2012, exceeded only by payments to hospitals (\$179B) and Medicare Advantage plans (\$136B).

represents about 16% of all income taxes collected by the federal government.

We highlight these data to illustrate the importance of Medicare program spending in federal budget calculations, and the relative magnitude of the program's spending under the physician fee schedule. These factors keep the program and the fee schedule, among other provider and health plan areas, squarely on the front burner in Congressional budget and legislative activities every year.



With respect to its closer look at physicians, among other findings, MedPAC reported:

- About 850,000 clinicians bill Medicare—550,000 physicians, and 300,000 nurse practitioners, physician assistants, therapists, chiropractors, and others.
- Medicare's payments for fee-schedule services relative to private insurer payments remained relatively constant at 81 percent of commercial rates for PPO's.
- Half of all Medicare beneficiaries seeking an appointment with a physician were able to see one within three days—this was found in 2001 and held true in 2011. However, MedPAC's tables (p.103) also reveal that about 24% of beneficiaries seeking an appointment waited 10-21 days or more to get one.

Finally, MedPAC devoted considerable analytical attention to the Medicare physician fee schedule's sustainable growth rate formula

(SGR) and other aspects of payment equity for physician services. Overall, MedPAC indicated:

- Repeal of the SGR is urgent, and beneficiary access must be preserved.
- The fee schedule must be rebalanced to achieve equity in payments between primary care and other services.
- Pressure on fee-for-service must encourage movement toward new payment models and delivery systems.
- Repeal of the SGR must be fiscally responsible (Note: In other words, repeal costs should be offset by spending reductions).

In closing, we note that the report is rich in discussions and data on medical services utilization, coding changes, physician practice input costs, other payment policies, and more. It is well worth attention for those seeking to understand the overall landscape in Medicare payment policy.

We turn now to summarizing the temporary physician fee schedule legislative fix, as well as other notable legislative provisions passed by the Congress at the close of March 2014.

Protecting Access to Medicare Act of 2014 (H.R. 4302)—Once again, the Congress evaded deep cuts in Medicare physician payments going into effect by passing time-limited legislation at the eleventh hour. The President signed the House and Senate passed version of H.R. 4302 into law on Tuesday, April 1, 2014. Despite extensive earlier House and Senate activity over several months to craft a permanent alternative to the SGR formula and institute new payment models (HR 4015/S 2000- The SGR Repeal and Medicare Provider Payment Modernization Act), agreement broke down on costly financing offsets. The cost of the permanent change was scored by CBO in the range of \$130 - \$180 billion over a ten-year budget window, depending on modifications.

This is the 16th short-term fix, and the American College of Physicians (ACP) suggested in an April 1 letter to House and Senate leadership that the aggregate cost of these fixes has exceeded \$150 billion. The ACP's letter, just one among many sent by major

medical associations and organizations, deeply protests the Congress's failure to act fully on SGR repeal and Medicare physician payment policy modernization.

The legislation, as enacted, postpones for one year the 24 percent fee schedule reduction that otherwise would have gone into effect on April 1. It contains 36 other health-related provisions and one PAY-GO provision. Over the period 2014-2019, CBO scored the cost of the fee schedule adjustment at \$14.7 billion, and over the 2014-2024 period, at \$15.8 billion. The entire bill was scored at a net \$17.7 billion over 10 years, due to offsetting reductions in outlays in later years.

To close this section, following is a short synopsis of select provisions, drawn from CBO and CMS products (see sources):

Per CMS, the new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on April 1, 2014. The law maintains the 0.5 percent update for such services that applied from January 1, 2014 through March 31, 2014 for the period April 1, 2014 through December 31, 2014. It also provides a zero percent update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015.

PHYSICIANS. The new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through December 31, 2014. It also provides a zero percent update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015. CMS states they are currently revising the 2014 MPFS to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. The 2014 conversion factor is \$35.8228.

EXTENSION OF WORK GPCI FLOOR. The existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2015. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS. The new law extends the exceptions process for outpatient therapy caps through March 31, 2015. Per CMS, providers of outpatient

therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2015. In addition, the new law extends the application of the caps, exceptions process, and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 5, Section 10.3.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received beginning on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit on incurred expenses for a beneficiary is \$1,920. There is a separate cap for occupational therapy services that is \$1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

The new law also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014 through March 31, 2015, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of \$3,700 for therapy services, including OPD therapy services, for a year. There are two separate \$3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services combined, and (2) occupational therapy services.

OVERPAID CODES. The Secretary of HHS is authorized to adjust pricing for overvalued codes based on data collected from physicians;

RADIOLOGY SERVICES. For radiology services completed on or after January 1, 2016, whether in physician offices or outpatient facilities, payment will be reduced by 5 percent and for subsequent years by 15 percent.

END-STAGE RENAL DISEASE PROSPECTIVE PAYMENT SYSTEM. Inclusion of oral drugs in payment bundles for dialysis is delayed until 2024. CMS is required to reduce otherwise applicable

market basket rates by 1.25 percent in 2016 and 2017, and by 1 percent in 2018;

MENTAL HEALTH. Medicaid community mental health grants are authorized for up to eight states for the establishment of two-year programs to begin September 1, 2017. There are a number of required services that must be provided under the grants to improve mental health services.

ICD-10 CODING IMPLEMENTATION. After two previous delays, the deadline by which Medicare would implement the new ICD-10 diagnostic and procedure code sets is delayed by one year, to October 1, 2015. We note that while this may be welcome news for many in the health care field, the delay is also costly and disruptive for many organizations that were in high testing and preparation mode for this year's target date;

TWO-MIDNIGHT RULE FOR HOSPITALS. Delays implementation of the controversial payment rule for hospitals, known as the two-midnight rule, to July 1, 2015. Stays spanning two midnights would generally be eligible for inpatient reimbursement, while shorter stays would be paid on an outpatient basis;

LABORATORY FEE SCHEDULE CHANGES. Effective January 1, 2016, diagnostic laboratories will be required to disclose their private payer rates every three years for the purpose of setting Medicare's payment rates (benchmarking concept). Individual codes would be capped at 10 percent from 2017-2019, and at 15 percent from 2020-2022;

MEDICAID DSH PAYMENTS. The law delays to fiscal year 2017 the start of scheduled annual Medicaid reductions to hospitals that treat a disproportionate share of low-income patients. The expired three-month SGR patch legislation had already delayed the start of the cuts to FY 2016.

EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS. The new law extends, through March 31, 2015, a provision that allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital.

EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM. The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program through March 31, 2015.

EXTENSION OF AMBULANCE ADD-ON PAYMENTS. Per CMS, the new law extends the following two expiring ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2015 and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through March 31, 2015. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, expired on June 30, 2013.

Please note that CMS indicates it will be issuing additional information on various provisions in the near future via the Medicare Learning Network (MLN Connects) site at www.CMS.gov.



(Sources: Congressional Budget Office, “Cost Estimate for the Protecting Access to Medicare Act of 2014,” March 26, 2014; CMS, MLN Connects, “Weekly Provider eNews”, April 2, 2014)

Conclusion—The current health reform dynamics operating within the health care system will continue apace into the foreseeable future. As we go to press, we note that House Budget Committee Chairman Paul Ryan released on April 1 a blueprint for a House Republican budget resolution. This particular budget exercise is not strictly required this year, since the Congress is operating under the two-year agreement that Mr. Ryan and Senator Patty Murray, as Chair of the Senate Budget Committee, negotiated late in 2013. Consequently, the Senate is not pursuing a formal budget resolution and Committee legislative process this year. (This *does not mean* there will be no legislation developed and acted upon in the Senate this year). However, Mr. Ryan has expressed a desire to produce a budget blueprint that Republicans can run upon in the 2014 mid-term elections. The House of Representatives passed a final resolution that hewed closely to Mr. Ryan’s proposed blueprint. Clearly, the politics of health care are now joined leading into those elections.

Budget resolutions do not contain specific program legislation; rather, they set broad budget parameters to guide authorizing Committees in their legislative work. Congressional Committees, such as the House Committee on Ways and Means, are expected to achieve budget resolution targets through legislative changes to programs within their jurisdiction. Such legislative changes must survive independent CBO analysis and scoring, and the voting process in the Committees and then on the House floor. In this context, a House of Representatives budget resolution does not specify what programs the Republicans would propose to replace the programs and health care spending priorities of current law. As we noted in Chapter I, until *specific legislation* is moved out of Committees and taken to the House (or Senate) floor and voted upon, there is no real record by which voters can judge what is lost and what is gained by a Party’s actions.

In brief, Mr. Ryan’s budget blueprint would require achieving deep reductions in Medicare

and Medicaid spending, as well as repeal of the ACA in its entirety, except for retention of all the savings (\$716 billion) that the ACA legislation generated. The blueprint includes repeal of the exchanges and all subsidies, and the ACA-based Medicaid expansion. The residual Medicaid and Children’s Health Insurance Programs would be consolidated into a block-grant program to states. The blueprint also would initiate conversion over time of the Medicare program into a private insurer, premium support model, while also modifying the basic design of the benefit package. The Medicare physician fee schedule SGR formula would be repealed and a new, deficit-neutral reimbursement system (unspecified) would replace the current fee schedule.

Budget resolutions are just the initial “shot over the bow.” Yet, competing ideas and priorities are important. The outlines of very different visions regarding the health care system will confront voters entering the mid-term elections. Regardless of the election outcome, ideas that seem initially unpalatable, under changing budget and societal dynamics, may become more, or even less, accepted. Only time will tell which social vision will prevail.

We close this report by highlighting our upcoming Medicare report. That report looks at the ways in which the Medicare program has been a platform for systemic health care reforms, especially under the ACA. There are many significant ACA-related and other policies enacted into the Medicare law that are beyond the scope of this report and that we think deserve deeper attention. Therefore, the Physicians Foundation will release this summer a comprehensive report focused on the extent to which the ACA’s systemic cost and quality objectives are being channeled through the regulatory and buying power of Medicare. We will also highlight certain other policies, such as those governing the Medicare coverage process, followed within the Centers for Medicare and Medicaid Services (CMS). Finally, conversion of Medicare to a premium support model is a persistent idea and will also be examined in that report.

As always, we hope that this report has been helpful. We thank you for your time and attention. ■

Budget resolutions are just the initial “shot over the bow.” Yet, competing ideas and priorities are important. The outlines of very different visions regarding the health care system will confront voters entering the mid-term elections.

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