

# INTRODUCTION TO THE AFFORDABLE CARE ACT (ACA)



## Overview & History of the Patient Protection and Affordable Care Act (ACA)

Prior to the passage of the Patient Protection and Affordable Care Act (ACA) there were over 47 million uninsured non-elderly individuals in the United States.<sup>i</sup> Additionally, the U.S. health care system faced many complex challenges related to access to care as well as costs and quality of care. When compared to other developed nations, the U.S. spends the most on health care per capita, but fails to produce better health outcomes. In this comparison, the U.S. ranked last in measures including access, patient safety, efficiency, and equity.<sup>ii</sup> With the urgent need to reduce spending, increase health insurance coverage and improve health care outcomes in mind, health care reform became a policy priority for President Barack Obama. The legislative details of the law were crafted jointly by the House and Senate dating back to early 2009.<sup>iii</sup> After several iterations, the ACA was signed into law on March 23, 2010 (Public Law 111-148).

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## Challenges to the Affordable Care Act

### National Federation of Independent Business (NFIB) v. Sebelius

Immediately following the ACA's passage in March 2010, a lawsuit was filed challenging the constitutionality of two key components of the law: the individual shared responsibility provision, also known as the individual mandate, which requires everyone who can afford health insurance to purchase it or face a penalty, and the universal, mandatory expansion of Medicaid eligibility to all individuals with income under 133 percent of the federal poverty level (FPL). The lawsuit, filed by several states and the National Federation of Independent Businesses, went before the Supreme Court two years later as *National Federation of Independent Business (NFIB) v. Sebelius*. The Supreme Court of the United States (SCOTUS) issued its ruling on June 28, 2012.

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<sup>i</sup> Kaiser Family Foundation, *Key Facts About the Uninsured Population*, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (October 5, 2015)

<sup>ii</sup> The Commonwealth Fund, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update*, <http://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-update> (June 23, 2010)

<sup>iii</sup> Cannan, John, "A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History," *Law Library Journal* 105:2, <http://www.aallnet.org/main-menu/publications/llj/llj-archives/vol-105/no-2/2013-7.pdf> (July 2013)

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## Supreme Court Ruling on the Individual Mandate

Under the individual mandate, the ACA requires that everyone carry health insurance coverage that is deemed affordable and meets minimum requirements. Failure to comply with the individual mandate can result in a financial penalty where the greater of \$325 or two percent of income is withheld in 2015, and then increasing yearly to a maximum amount equal to the least expensive level health plans in the state health exchanges for that year.

In the *NFIB v. Sebelius* Supreme Court case, the plaintiffs argued that Congress does not have the power to require the majority of Americans to purchase health insurance. On this matter, the Supreme Court (SCOTUS) recognized that the individual mandate functions similarly to a tax, in that it is collected by the IRS and may produce some revenue for the government. Therefore, the court ruled in favor (five to four) of the individual mandate noting that it does not exceed Congress's constitutional power to levy taxes.

## Supreme Court Ruling on Medicaid Expansion

Medicaid is administered by the states and funded jointly by the states and the federal government. As such, the federal government gives states the flexibility to set eligibility thresholds that will cover certain segments of the population. Prior to the ACA, the groups mandated for coverage included low-income children and their parents, low-income pregnant women, low-income elderly individuals, and individuals living with disabilities. These groups had to meet certain income requirements based on family size and income in relation to the FPL.

The ACA sought to expand Medicaid's mandatory coverage by requiring states to cover all individuals under 65 whose household income was below 133 percent of the FPL. This would mean that previously ineligible populations, for example adults who were not disabled, and those who did not have dependent children, could now apply to gain coverage through the Medicaid program. If states expanded Medicaid, the federal government would fund 100 percent of the expansion through 2016 and gradually decrease thereafter, to 90 percent. Failure to meet the new

mandatory Medicaid coverage could result in withholding of *all* Medicaid funding for the state, as enforced by the Secretary of Health and Human Services (HHS). In its June 2012 ruling, SCOTUS found that the Medicaid expansion was unconstitutionally coercive because states did not receive appropriate notice to consent to the expansion and the HHS secretary had the power to withhold all Medicaid funds to the state. The Supreme Court found a solution to this violation by restricting the Secretary's enforcement authority, which means that the Medicaid expansion is now optional for the states. Overall programmatic changes to Medicaid as a result of the ACA remain intact.

## King v. Burwell

In spring 2015, SCOTUS heard oral arguments for another case challenging provisions of the ACA in the court case *King v. Burwell*. This case hinged on the legality of advance premium tax credits (APTCs) also referred to as "subsidies" in states that do not operate their own health insurance exchanges. At the time of the court case, 34 states relied on the federal government to operate their exchanges, thus having implications for millions of individuals relying on the subsidies in order to afford coverage. In June 2015, SCOTUS ruled in favor of upholding the availability of subsidies for all individuals, regardless of the type of exchange.<sup>iv</sup>

## Key Provisions of the ACA

The ACA is an historic law aimed at addressing key challenges facing the U.S. health care system including:<sup>v</sup>

### Increasing access to health care by:

- Providing enhanced federal funding to support states opting to expanding Medicaid to all non-elderly individuals at or below 133 percent of the FPL
- Creating state-based Health Insurance Marketplaces (Exchanges) that offer subsidized health insurance plans
- Extending coverage for young adults through age 26
- Implementing an individual shared responsibility

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<sup>iv</sup>Kaiser Family Foundation, *King v. Burwell*, <http://kff.org/king-v-burwell-resources-on-the-u-s-supreme-court-case/>

<sup>v</sup>U.S. Department of Health and Human Services, *Key Features of the Affordable Care Act by Year*, <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html>

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provision (individual mandate). This requires most<sup>1</sup> individuals to acquire a minimum level of health care coverage for themselves and their legal dependents

- Incentivizing employment in primary care (physicians, nurses, physician assistants) through scholarships and loan repayment
- Strengthening and expanding support for community health centers, school-based health centers, and workplace wellness programs
- Providing higher reimbursements to rural health care providers
- Creating a core set of essential health benefits, which requires all new insurance plans and existing plans offered through the Health Insurance Marketplace to cover the following benefits: ambulatory patient services (outpatient care without admission to hospital); emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drug coverage; rehabilitative and habilitative services/devices; laboratory services; prevention and wellness services; chronic disease management; and pediatric services (including oral and vision care).<sup>vi</sup>

## Improving quality of health care by:

- Requiring reporting on health disparities, which will be used to reduce existing disparities
- Promoting integrated health care systems (i.e., Accountable Care Organizations)
- Establishing the Center for Medicare and Medicaid Innovation to analyze and assess strategies for quality improvement and health care cost containment
- Supporting patient-centered medical homes (PCMH)
- Creating value-based purchasing that ties physician and hospital payments to improved health outcomes

## Protecting consumer rights by:

- Prohibiting discrimination based on pre-existing conditions and gender
- Eliminating annual dollar limits on coverage of essential benefits
- Making it illegal for insurance companies to rescind coverage based on an inadvertent omission or technical mistake in the application
- Creating the 80/20 rule requiring insurers to spend at least 80 percent of premiums (or 85 percent, depending on size of company) on health care services and quality improvement

## Lowering health care costs by:

- Reducing paperwork/administrative costs through electronic health records
- Promoting preventive health care services through investment in the Prevention and Public Health Fund
- Bundling payments based on one episode of care
- Investing in demonstration projects that test new models of care designed to improve outcomes and lower costs

## The ACA and Implications for the MCH Population

The majority of the provisions of the ACA impact MCH populations. Some examples are:

- The ACA ends gender rating that previously allowed insurance companies to charge women higher premiums than men for the same insurance plans.
- The ban on denial of coverage due to pre-existing conditions offers protections for the CYSHCN population.
- Young adults will gain access to coverage through their parents' health care plans up to age 26.

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<sup>vi</sup> U.S. Department of Health and Human Services, *What Marketplace Health Insurance Covers*, <https://www.healthcare.gov/what-does-marketplace-health-insurance-cover/>

<sup>1</sup> Exemptions may apply to individuals in certain religious groups, individuals that are undocumented, or those that are incarcerated.

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- Youth aging out of foster care can retain Medicaid benefits to age 26.
- CYSHCN on Medicaid or CHIP may receive both hospice care and care related to their illness simultaneously.
- Essential health benefits apply to all plans sold on the Health Insurance Marketplace or all new non-grandfathered plans sold outside of the Health Insurance Marketplace. Essential health benefits include maternal and newborn care and pediatric dental and vision care for children. Essential health benefits also include rehabilitative and habilitative services. In February 2015, HHS issued a final rule indicating that habilitative services should be defined using the uniform glossary of health coverage and medical terms as follows: “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”<sup>vii</sup>
- In the states that are moving forward with Medicaid expansion, women who were previously ineligible may now gain coverage.
- There are no co-payments for recommended preventive services. New insurance plans are required to cover services such as screening for breast and/or cervical cancer, well woman exams, screenings/vaccines for HPV and/or sexually transmitted infections, and screening for domestic violence.<sup>viii</sup>
- Coverage of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt “religious employers.”
- Maintenance of Effort (MOE) stipulations, in effect until 2019, prohibit states from changing the income eligibility criteria of Medicaid and CHIP that were in place when the ACA took effect.
- \$1.5 billion in initial funding for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was authorized under the ACA.<sup>ix</sup> In 2015, funding for the MIECHV program was reauthorized through 2017 at \$400 million/year.
- \$75 million was provided annually between 2010-2014 for the Personal Responsibility Education Program (PREP) to provide comprehensive sexual education to youth. In 2015, Congress extended the program through Fiscal Year (FY) 2017 at its current annual funding level of \$75 million.
- Reinstated funding—\$50 million annually between 2010-2014—for the Title V abstinence-only education program. Funding for the program was reauthorized at \$50 million for FY2015 and at \$75 million/year for FY2016 and FY2017.

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<sup>vii</sup> Federal Register, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, <https://www.federalregister.gov/articles/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016/#h-105> (February 2015).

<sup>viii</sup> Kaiser Family Foundation, *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/> (August 4, 2015).

<sup>ix</sup> Health Resources and Services Administration, *Home Visiting Grants & Grantees*, <http://mchb.hrsa.gov/programs/homevisiting/grants.html>

## Test your knowledge

1. Under the ACA, most insurance plans will not charge co-pays for preventive care. Which of the following is considered a preventive service?
  - a. Screening for domestic violence
  - b. Screening for HPV or sexually transmitted infections
  - c. Screening for breast and/or cervical cancer
  - d. All of the above
2. True or False: Under certain circumstances, an individual may be exempt from the individual mandate.
3. Which of the following is false?
  - a. The ACA contains several provisions to increase access to care.
  - b. The ACA seeks payment reform by promoting a fee for service reimbursement model.
  - c. The ACA prohibits discrimination based on pre-existing conditions.
  - d. The ACA is incentivizing workforce development in primary care.



## Find Out in Your State

1. What services are covered in your state's essential health benefit benchmark plan? Are there any gaps in coverage of services deemed important for your state's MCH populations?
2. Is your state using ACA funds to develop and expand community health programs? If yes, how can MCH populations better utilize those services?

Test Your Knowledge Answers: 1. d  
2. True  
3. b

This document is part of *The Affordable Care Act: A Working Guide for MCH Professionals*, available in its entirety on the Web at <http://www.amchp.org/Transformation-Station/Pages/ACA-101.aspx>

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