Affordable Care Act ("Obamacare")

"A…national survey conducted for Democracy Corps and the Women's Voices Women's Vote Action Fund shows an intense new majority for implementing and improving the Affordable Care Act. A minority of voters want to repeal or replace 'Obamacare,' which has been the core demand of the Republicans in Congress who have shut down the government…Just 38 percent now clearly oppose the Affordable Care Act. While likely voters divide evenly on the plan, 8 percent oppose the law because it does not go far enough. As a result, just 38 percent oppose the law because it is big government…These shifts are being driven by movement among key groups who are the first to see the benefits. The biggest shifts on favorability since 2010 come not from partisans but from independents and key groups, including unmarried women, white non-college voters, and seniors. These are also the groups most likely to report that they are seeing the benefits of the law…A working women's agenda, including health care reform, is empowering for unmarried women. Unmarried women see health care as one essential part of broader economic goals for women. Because many unmarried women have to make healthcare choices based on basic household finances, a message connecting healthcare to pocket-book policies for working women is very powerful for this group and aligns closely with how they think about healthcare…Two-thirds of the Rising American Electorate want to see the ACA implemented – almost half strongly (unmarried women: 67% believe—including 48% strongly believe, 'we should implement and fix the health care reform law,' versus 25% who believe 'we should repeal and replace the health care reform law').

--"38 percent: A new national survey highlighting the political realities on health care," October 16, 2013 memo on survey by Greenberg Quinlan Rosner for Women's Voices Women's Vote Action Fund and Democracy Corps

Background

Prior to 2009, the United States was facing a crisis with respect to its health care system, as summarized in a report to Congress that year by the nonpartisan Congressional Research Service:

Health care reform is a major issue, driven by growing concern about millions of people without insurance coverage, continual increases in cost and spending, and quality shortcomings. Commonly cited figures indicate that more than 45 million people have no insurance, which can limit their access to care and ability to pay for the care they receive. Costs are rising for nearly

everyone, and the country now likely spends over $2.5 trillion, more than 17% of gross domestic product (GDP), on health care services and products, far more than other industrialized countries. For all this spending, the country scores but average or somewhat worse (than other nations) on many indicators of health care quality, and many may not get appropriate standards of care.[1]

In addition to these general concerns about the availability, cost and effectiveness of the American health care system, prior to 2010, there was limited federal regulation of private health insurance, with states serving as the primary regulators, which resulted in great variation in patient protections from state to state. Thus, there was no national prohibition on such practices as:

- Discrimination in health care based on race, national origin, age, disability or sex;
- Discrimination in the private health insurance market based on gender, with most states allowing insurance companies to use gender in setting premium costs (generally resulting in women being charged more than men for the same coverage);
- Imposition of lifetime and annual limits on the value of health insurance benefits;
- Denial of coverage for those with preexisting health conditions;
- Imposition of cost-sharing "co-payments" for preventive health services; and
- Removal of young people over age 18 from their parents' health insurance plan.[2]

In 2013, the percentage of Americans without health insurance for the entire calendar year was 13.4%, with 42 million Americans still uninsured. The uninsured rate was significantly higher for Hispanics (24.3%) than for non-Hispanic whites (9.8%), Asians (14.5%) or African Americans (15.9%). It was also higher for low (under $25,000: 21.6%) and middle ($25,000-$49,999: 18.7%) income households than for their more affluent counterparts ($50,000-$74,999: 13.1%; $75,000-$99,999: 9.7%; $100,000-$149,999: 6.3%; $150,000 or more: 5.3%). In terms of type of coverage, 53.9% had private, employment-based coverage, 11.0% had directly purchased private insurance, 17.3% had Medicaid, 15.6% had Medicare, and 4.5% had military health care insurance. (Note that these categories are not mutually exclusive because people could be covered by more than one form of insurance.)[3]

Among those 18 and over, the uninsured rate in 2013 was somewhat higher for men (16.7%) than for women (13.9%), but unmarried women (16.9%) were much more likely to be uninsured than married women (11.0%). Furthermore, there was considerable variation in those lacking health insurance within the categories of unmarried women, with widows (5.5%) being much less likely to be uninsured than the other groups (divorced: 16.3%; never married: 20.6%; separated: 23.5%).[4]

A Kaiser Family Foundation study found that in 2013, 18% of women ages 18-64 were uninsured, 57% had employer-provided insurance (as an employee or dependent), 9%

were enrolled in Medicaid, 7% purchased individual insurance and 9% had some other form of coverage, didn't know or refused to answer. Among low-income women (those with incomes below 200% of the federal poverty level) in this age group, fully 40% were uninsured. African American women (22%) and Latinas (36%) were also more likely than white women (13%) ages 18-64 to be uninsured.[5]

Affordable Care Act of 2009

Although many attempts had been made over the years to reform the American health care system, the issue became particularly prominent in 2009 and 2010, culminating in the enactment of the *Patient Protection and Affordable Care Act* (generally referred to as the Affordable Care Act or "Obamacare"), which passed the Senate on 12/24/2009 by a vote of 60-39 (Yes: 58 Democrats, 2 Independents; No: 39 Republicans) and the House on 3/21/2010 by a vote of 219-212 (Yes: 219 Democrats; No: 34 Democrats, 178 Republicans). It was signed into law by President Obama as Public Law 111-148 on 3/23/2010.[6]

In March 2010, Florida (joined by 25 other states) filed a lawsuit challenging the constitutionality of the Affordable Care Act, specifically with respect to the penalty to be imposed on individuals who do not obtain health insurance (also known as the "individual mandate"), as well as the law's expansion of the Medicaid program. On June 28, 2012 the Supreme Court upheld the constitutionality of the individual mandate, finding that it represented a constitutional exercise of Congress' power to levy taxes.[7]

Many of the ACA's key insurance reforms went into effect prior to 2014.

- Insurance plans that offer dependent coverage must allow adult children under the age of 26 to remain on their parents' plan. Prior to enactment of the Affordable Care Act (ACA) the vast majority of young adults over the age of 18 were not eligible for such coverage. The Department of Health and Human Services (HHS) estimates that, as of March 4, 2015, 5.7 million young adults ages 19-25 had received coverage under their parents' plans as a result of the ACA.[8] The 2013 Kaiser Women's Health Survey found that coverage under a parent's plan is now the leading method through which women ages 18-25 get their health care coverage, with 45% of such women gaining coverage in this way (19% uninsured, 12% Medicaid, 8% individual market, 8% employer-sponsored for self, 3% employer-sponsored as spouse/partner, 5% other/refused).[9]
- Insurance plans may not limit or deny benefits, or deny insurance coverage to children under age 19 because the child has a pre-existing health condition. According to a November 2011 analysis by HHS, 24% of children under age 18 (representing 17 million children) had a pre-existing condition that could have led to a denial of coverage prior to the ACA.[10]

- Insurance plans beginning on or after September 23, 2010 are required to provide coverage for preventive health services without imposing any form of cost-sharing through co-payments, co-insurance or deductibles. These preventive services include wellness visits and cancer screenings. More specifically for women, coverage must include: mammograms; screenings for cervical cancer and gestational diabetes; contraception and contraceptive counseling; breastfeeding support; and domestic violence screening and counseling. The Center for American Progress reported in 2012 that the average potential cost of oral contraceptives for women without insurance could be as much as $1,210 per year.[11] HHS estimates that, as of June 2014, 76 million Americans have received expanded coverage of one or more preventive services without cost-sharing due to the Affordable Care Act, including 29.7 million women ages 18-64, and 18.6 million children under the age of 18. In addition, 24.4 million more prescriptions for oral contraceptives were dispensed with no co-pays in 2013 compared to 2012, resulting in an estimated savings of $483.3 million in out-of-pocket costs for women.[12]
- Insurance plans may not retroactively cancel coverage after an individual becomes sick or injured.
- Effective for plans beginning on or after September 23, 2010, insurance plans that cover obstetrical or gynecological care must permit a woman seeking OB/GYN care to choose her service provider (as long as the provider is in the network and is an OB/GYN specialist) without obtaining authorization from the insurance company or referral from a doctor.
- Effective for plans beginning on or after September 23, 2010, insurance plans may not place lifetime limits on the dollar value of insurance coverage. Under the ACA, 105 million Americans (including 27.8 million children under age 18 and 39.5 million adult women, ages 18-64) are no longer subject to lifetime limits on health benefits.[13]
- Effective for plans beginning on or after September 23, 2010, insurance plans must spend at least 80% of revenue from premiums on medical claims (called the 80/20 or Medical Loss Ratio rule). As a result of efficiencies promoted by this and other ACA requirements, in 2013, the 78 million consumers who have insurance through their employer, or purchase their own insurance in the individual market, saved an estimated $3.85 billion in health insurance premiums (for a total of $7.3 billion in premium savings since the 80-20 rule went into effect) and 6.8 million enrollees received $332 million in refunds from insurance companies (for a total of $1.9 billion in refunds since 2011).[14]
- Insurance companies, health care providers and health programs that receive federal funding are prohibited from discriminating on the basis of race, national origin, age, disability or sex. This provision – found in Section 1557 of the ACA – is the first federal statute to broadly prohibit sex discrimination in virtually all parts of the health care system.[15]

- To help finance the ACA, new annual fees were imposed on the pharmaceutical manufacturing sector ($2.8 billion in 2012-2013).

Most of the ACA – including its expansion of health care coverage and benefits – went into effect on January 1, 2014**.**

- Insurance plans may not limit or deny benefits, or deny insurance coverage to any individual, regardless of age, because of a pre-existing health condition, such as breast cancer. It is estimated that as many as 129 million Americans under the age of 65 have some type of pre-existing health condition that, prior to the ACA, could have led to denials of insurance coverage.[16] After the enactment of ACA but before the effective date of this provision, 27,000 women who were denied coverage because of pre-existing conditions were enrolled in the Pre-Existing Condition Insurance Plan (PCIP).[17]
- Insurance plans may not use gender or health status in determining premium costs. In other words, women will no longer be charged more than men for the same health coverage, a practice that was widespread prior to enactment of the ACA. A 2012 study by the National Women's Law Center found that "in the capital cities of states that permit gender rating, 92% of the bestselling plans charge 40 year-old women more than 40 year-old men for identical coverage." The Center calculated that such discrimination cost women approximately $1 billion a year in additional health insurance costs.[18]
- Insurance plans must accept every applicant for coverage as long as the applicant agrees to the terms and conditions of the insurance offer, and plans must renew coverage at the option of the policyholder.
- Most U.S. citizens and legal residents are required to have health insurance or to pay a penalty. Those who have health insurance (through their employer, Medicare, Medicaid or the new exchanges) are not subject to the penalty, nor are low income households, and additional exemptions will be granted because of financial hardship or religious beliefs. It is estimated that only two percent of Americans will be subject to the penalty, which is set at the higher of $95 or 1.0% of taxable income in 2014, rising to $695 or 2.5% of taxable income in 2016. On October 23, 2013, the Administration clarified that, as long as an individual had purchased insurance coverage by March 31, 2013, he or she was not subject to the penalty, even if the insurance policy had not taken effect by that date.[19]
- To help finance the ACA, the following fees will be imposed
    - An annual fee of $2,000 per full-time employee for employers of 50 or more full-time workers who do not offer health insurance coverage (with the first 30 employees excluded from the assessment).[20] This is the so-called "employer mandate."
    - An annual fee on the health insurance sector ($8 billion in 2014).[21]

In response to concerns from consumers receiving notices from their insurance companies that their previous insurance plans were being cancelled because they did not include all of the benefits required under the ACA, the Obama Administration announced on March 5, 2014 that states would be given latitude to let people renew such policies through October 2017.[22]

Delay in the Employer Mandate

On July 2, 2013, the Administration announced that the effective date of the requirement that employers of 50 or more workers who do not offer affordable health insurance coverage to their workers must pay a penalty was being postponed from January 1, 2014 until the beginning of 2015. In making the announcement the Treasury Department stressed that the action was being taken to allow more time for businesses to comply with the reporting requirements that underlie the calculation of penalties: "First, it will allow us to consider ways to simplify the new reporting requirements consistent with the law. Second, it will provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees."[23]

On February 10, 2014, Treasury announced an additional delay – until January 1, 2016 – in the effective date of the employer mandate for employers of 50-99 workers. A transition period was also announced for employers of 100 or more workers, with such employers required to offer health coverage to 70% of full-time employees in 2015 and 95% in 2016 and later years, or be subject to the penalties.[24]

An analysis by the Rand Corporation reported that the impact of a one-year delay in the employer mandate will be minimal in the short term, though further postponement would have a significant effect on revenues for funding the ACA over the long run.

Only 300,000 fewer people, or 0.2% of the population, will have access to affordable insurance in 2014 because of the delay. About 1,000 fewer firms, or 0.02%, will offer coverage in 2014 given the delay…We estimate that the one-year delay in enforcement amounts to $11 billion less in revenue for the federal government--$7 billion less in penalties that would be assessed on firms that do not offer insurance and $4 billion less from fines of employers that offer unaffordable care. A full repeal of the employer mandate, not merely a one-year delay, would result in the loss of approximately $149 billion in federal revenue over the next ten years.

The same Rand study highlighted the relatively limited impact the employer mandate is expected to have on businesses and workers once it takes effect: "We estimate that only about 0.4% of firms, employing approximately 1.6% of workers, will pay a penalty for not offering health insurance at all. Based on current employer health plan contribution rates,

we estimate that 1.1% of firms will pay some penalty for offering unaffordable coverage to a total of less than 1% of the workforce."[25]

Health insurance exchanges

In order to provide more choices and price competition for Americans not covered by employer or government-sponsored group insurance plans, the Affordable Care Act established state-based health insurance exchanges to allow individuals and small businesses (of up to 100 employees) to purchase qualified coverage from among competing insurance plans. If a state is unable or unwilling to establish a state-based exchange or to enter into a state-federal exchange partnership, the U.S. Department of Health and Human Services is to establish and operate a federally-facilitated exchange in that state.[26]

Though any adult can utilize the exchanges, they are intended primarily for those who don't currently have insurance, or who purchase their own insurance directly. Individuals covered by employer-provided insurance, Medicaid, Medicare, the Child Health Insurance Program (CHIP), and veterans and military health plans don't have to use the exchanges.[27]

Enrollment in the health care exchanges began on October 1, 2013. Enrollment websites were then operational in fourteen of the sixteen approved state-based exchanges (CA, CO, CT, HI, KY, MD, MA, MN, NV, NY, OR, RI, VT, WA) plus the District of Columbia, with the federal government running enrollment for the 27 states that had deferred to a federally-facilitated exchange (AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WY), the seven that had been approved for state-federal partnerships (AR, DE, IL, IA, MI, NH, WV), and two of the state-based exchanges that were not yet prepared to assume full responsibility (ID, NM).[28]

Serious problems were noted in the federal enrollment website (HealthCare.gov) from the outset, with some reports indicating that it locked up shortly after activation at midnight October 1. Part of the difficulty was heavier than anticipated usage (with over 20 million reported visits to the site as of October 26), and the decision made by site designers to require visitors to the site to create an account before browsing for information. However, numerous other glitches were also discovered, including erroneous information forwarded by the federal site to insurance companies for completing the enrollment process, and ongoing delays and system lock-ups that initially resulted in 30% of users being unable to complete the application process despite repeated efforts to do so. One report indicated that there were as many as 100 technical problems with the federal website that needed to be fixed. In October 24, 2013 testimony to the House Energy and Commerce Committee, private contractors hired by the federal government to create the website cited inadequate testing before the site was launched as the major contributor to the subsequent

malfunctions. In response to these and other concerns, on October 25 the White House announced that the private firm Quality Software Services Inc had been hired to take over management of the federal enrollment site, with a deadline of November 30 for fixing the problems.[29]

Problems were also being reported from a number of the state-based exchanges as well, with the State of Oregon, for example, reporting that as October 24, no one had been successfully enrolled through its exchange website.[30]

In May 2014, the Obama Administration announced that additional changes and improvements would be made in the federally facilitated exchange and its web site (HealthCare.gov) prior to the beginning of the next enrollment period in November 2014, including a new home page, visual design and tools to assist consumers in learning about the program, comparing different plans without having to create an account, and obtaining localized assistance. In addition, new software is to be employed for log-in and creation of individual accounts, the portion of the overall system that was particularly problematic in the initial sign-up period. Finally, the new system is to be optimized for mobile devices, and run on Amazon.com Inc.'s cloud computing service. The principal remaining problem with the initial sign-ups was the existence of a backlog of approximately two million applications containing discrepancies, primarily in either income projections or immigration status.[31]

In spite of the initial problems encountered by the federally facilitated exchange, all of the 36 states that utilized it for 2014 enrollments did so again for 2015 (with Oregon switching from a state to the federally facilitated exchange), with Kaiser reporting, "Election year politics, tight deadlines and problems with health insurance exchanges in Oregon, Maryland and Hawaii dampened the interest of lawmakers in other states to form their own exchanges [and] the success of the federal exchange website, www.healthcare.gov, in enrolling millions of people after a notoriously rocky rollout also limited demand for state-run marketplaces, experts said."[32]

As of May 2015, thirteen states (CA, CO, CT, HI, ID, KY, MD, MA, MN, NY, RI, VT, WA) and the District of Columbia are operating state-based exchanges. Seven other states (AR, DE, IL, IA, MI, NH, WV) have entered into a state-federal partnership arrangement utilizing the federally facilitated exchanges. AR and IL indicated their intention to operate as full state-run exchanges beginning in 2015, but AR has postponed that conversion until the fall of 2016 (with coverage beginning in 2017) and IL has taken no further action toward creating a state-based exchange.

Another three states (NV, NM, OR) are "federally supported marketplaces," under which the state operates the administrative authority but the federal enrollment website is utilized. OR had previously operated a state-based exchange but, because of problems, in April 2014 decided to convert to the federal website.

The other 27 states (AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WY) are utilizing federally facilitated exchanges. MS and UT were given approval to operate Small Business Health Options (SHOP) Marketplaces, which are limited to small business owners (50 or fewer workers) and their employees. Enrollment in the exchanges began on October 1, 2013, with coverage beginning on January 1, 2014, and the initial enrollment period closing on March 31, 2014 (though extensions were granted for those who had attempted to purchase health insurance by that date but had not been able to complete the process). The second open enrollment period ran from November 15, 2014 through February 15, 2015,[33] though a "Special Enrollment Period" (from March 15 through April 30, 2015) was provided for those in federally-facilitated exchange states who did not have health insurance coverage in 2014 and were subject to the tax penalty for not having such insurance.[34]

Each exchange must offer at least two multi-state insurance plans, and at least one plan must be offered by a non-profit. Each exchange must offer plans that provide "essential health benefits" (including, at least, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services) with options covering 60%, 70%, 80% or 90% of costs (depending on the premium charge). These "essential health benefits" must also be included in all new health insurance plans offered outside of the exchanges. States are permitted to prohibit plans participating in their exchange from providing coverage for abortions. Individuals making up to $43,000 and families making up to $88,000, who are not eligible for Medicaid or not enrolled in an employer's qualified health plan are eligible for federal subsidies or premium credits to reduce their costs.[35]

Of particular relevance to women, maternity coverage (included as an "essential health benefit" that must be in all new health insurance plans, beginning January 1, 2014) had been largely unavailable in the individual insurance market. The National Women's Law Center (NWLC) reported that, prior to the ACA, only 6% of individual health insurance policies in the 41 states that did not mandate such coverage included maternity services. (The figure rose to 12% if the nine other states are included.)[36] An estimated 8.7 million women with individual insurance have gained coverage for maternity services under the ACA.[37]

However, a recent survey by NWLC of insurance plans offered in the health insurance exchanges operating in 15 states, representing both federal and state-based exchanges (AL, CA, CO, CT, FL, ME, MD, MN, NV, OH, RI, SD, TN, WA, and WI), found a number of violations in the implementation of ACA requirements for women's health coverage, with over half of all plan issuers offering "coverage that violates the ACA's standards:"

- 14 issuers in seven of the states "offer maternity coverage that does not comply with the ACA, such as excluding maternity care coverage for dependents;"
- 56 issuers in thirteen states "offer coverage of preventive services that does not comply with the ACA, from imposing impermissible limits on coverage of breastfeeding supports and supplies, to not covering well-woman visits as required, to offering coverage of genetic testing that does not comply with the law, to failing to offer birth control coverage as required by law;"
- One issuer in one state "impermissibly limited coverage of abortion;"
- 7 issuers in 4 states "impermissibly limit essential health benefits in ways that restrict women's access to critical services, such as improperly limiting drug coverage and maintenance therapies or establishing waiting periods for certain services;" and
- 96 issuers in 12 states "offer coverage that does not comply with non-discrimination provisions of the ACA, such as violating prohibitions on sex discrimination, restricting coverage based on age, excluding care for transgender people, or excluding coverage of chronic pain treatment."[38]

Medicaid

Another of the key provisions of the Affordable Care Act was the *expansion of the Medicaid program to cover nearly all low-income individuals.* This was to be accomplished by setting a national Medicaid eligibility floor of 138% of the federal poverty level for children and non-elderly adults ($15,415 for an individual and $26,344 for a family of three), beginning in 2014.[39] To help states finance this expansion, under the ACA the federal government would finance 100% of the costs for newly eligible individuals from 2014 to 2016, with the federal share gradually declining to 90% in 2020 and thereafter. The ACA also streamlined and simplified the enrollment process to facilitate the increased participation, and sought to restrain expenditures by reducing payments to hospitals and creating pilot programs to test out cost-effective alternatives to the current administration of the program.[40]

In March 2012, the Congressional Budget Office (CBO) estimated that the ACA's Medicaid elements would provide health care coverage for an additional 17 million Americans by 2016, at a cost of an additional $795 billion over the ten-year period from 2012-2021. (A small portion of both the increased coverage and the increased costs would be in the Child Health Insurance Program.)[41]

Though in its June 2012 ruling the Supreme Court upheld the constitutionality of the individual mandate portion of the Affordable Care Act, the Court invalidated the expansion of Medicaid coverage, finding it to be unconstitutionally coercive of states because they were given inadequate notice to voluntarily consent and the federal government could withhold all existing Medicaid funds for a state that did not comply. To remedy this

situation, the Court ruled that the federal government may not withhold a state's existing Medicaid funding for failure to comply with the ACA's expansion of Medicaid eligibility, with the practical effect of making the expansion optional for the states.[42]

In the wake of the Supreme Court decision, CBO re-estimated the impact on Medicaid coverage and spending. It calculated that, by 2022, 11 million additional persons would be covered by Medicaid, rather than the 17 million in the earlier estimate. Expenditures would drop accordingly, with the 11-year 2012-2022 (note the additional year compared to the March estimate above) costs decreasing by $289 billion, to $931 billion.[43] In a separate analysis by the Urban Institute, it was calculated that if all states opted for the ACA's Medicaid expansion, over seven million additional women would gain health care insurance, including 4.6 million between the ages of 19 and 44.[44]

As of May 26, 2015, 28 states (AZ, AR, CA, CO, CT, DE, HI, IL, IN, IA, KY, MD, MA, MI, MN, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV) and the District of Columbia have implemented the Medicaid expansion (of which AR, IN, IA, MI, NH and PA have received federal waivers for alternative approaches to Medicaid expansion). One additional state (MT) has adopted the Medicaid expansion, but federal waiver approval is required before it can go into effect. The other 21 states (AL, AK, FL, GA, ID, KS, LA, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI[45] and WY) are not proceeding with the ACA-backed expansion at this time, though the issue is under active consideration in three of these (AK, FL, UT).[46]

The Kaiser Family Foundation reported in April 2015:

If the 21 states that have not expanded Medicaid were to do so, 4.3 million more people would have health coverage in 2016. Many of the states that have decided against Medicaid expansion are those who would gain the most…Numerous studies where a combination of public and private research has examined fiscal effects in all relevant categories—that is, state costs from increased Medicaid enrollment, state savings from increased federal match for current beneficiaries, state savings on non-Medicaid health care costs, and state revenue effects of expansion—have shown that, on balance, Medicaid expansion would help, not hurt state budgets over a multi-year period extending well beyond 2016…There is also evidence that the ACA is already having an impact on health care provided to the uninsured. A number of reports are finding that hospitals in Medicaid expansion states showed overall declines in self-pay and charity care, while hospitals in non-expansion states showed no change beyond normal variation.[47]

The National Women's Law Center calculated that, as of October 2014, 3.119 million potentially eligible low-income women resided in states that had not yet chosen to expand Medicaid coverage. The report found that "these women fare significantly worse in our health care system than insured women with similar family incomes…Across nearly all of [certain CDC] measures, which include general access measures indicative of integration

into the health care system and utilization measures for several preventive services that states must cover for individuals eligible for expanded Medicaid coverage, women who would be eligible for Medicaid coverage fare worse than insured women with the same income. This is true on a national level as well as on a state level in the 22 states that have not expanded Medicaid."[48]

Medicare

The ACA contained a number of provisions designed to strengthen the Medicare program by improving benefits for prescription drugs and preventive services, seeking to curb waste and excessive charges by health care providers, and making high-income seniors contribute more to extend the solvency of the Medicare HI trust fund. More specifically, the new law:

- *Closes the coverage gap (also known as the "donut hole") in the Medicare Part D prescription drug program* by reducing the proportion of prescription drug costs borne by beneficiaries from 100% in the "doughnut hole" prior to the law's passage to just 25% by 2020. According to HHS, over two million women had already benefited from this provision by 2011, for a savings of $1.2 billion in prescription costs.[49] As of February 2015, 9.4 million Medicare beneficiaries had saved over $15 billion for an average savings of $1,598 per person.[50] (Fifty-seven percent of Medicare beneficiaries are women.)[51]
- *Improves coverage of preventive health care services* by covering one free annual comprehensive health assessment visit, and eliminating coinsurance or deductibles for many preventive services, including mammograms and cervical cancer screenings.[52] (The 26.8 million female Medicare beneficiaries are eligible for these services.)[53] In 2014, an estimated 39 million Medicare beneficiaries took advantage of at least one preventive service with no cost-sharing, including 4.8 million who utilized the Annual Wellness Visit.[54]
- *Makes a number of changes in reimbursement of medical service providers designed to slow the cost growth in the Medicare program*, including gradually reducing federal payments to Medicare Advantage plans while providing bonuses to such plans receiving high quality ratings; establishing a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the program's growth rates exceed a target rate (though the Board is prohibited from proposing changes that ration care or modify benefits, eligibility, premiums or taxes); and reducing payments for certain medical providers (but not physicians), but providing increased payments for primary care physicians and rural health care providers.[55] These changes have helped to slow the rate of growth in Medicare spending and thereby extend the solvency of the Medicare trust fund. The most recent Medicare Trustees report (July 2014) found that since enactment of the ACA, per capita Medicare spending has increased by just 0.8% annually, well below the 3.1% annual increase in overall national health expenditures in the same period. The Trustees now project

that the Medicare hospital insurance trust fund will remain solvent until 2030, 13 years longer than its projection made in 2009. As a result, it is likely that the Part B premium for beneficiaries will remain unchanged from the 2013 premium for the second straight year.[56]

- *Promotes reforms in health care delivery and payment systems* through such measures as value-based purchasing for providers and the creation of a new Center for Medicare and Medicaid Innovation to test new payment and service delivery alternatives.
- *Asks high-income citizens to pay more to help extend the solvency of the Part A HI trust fund* by increasing the Medicare Health Insurance payroll tax for higher income taxpayers (individuals making over $200,000 a year, and couples making over $250,000) from the previous 1.45% of earnings to 2.35% beginning in 2013.[57]

The Congressional Budget Office (CBO) estimated (in July 2012) that the ACA will reduce net spending on Medicare by $716 billion between 2013 and 2022, with most of the savings coming from reductions in payments to service providers other than physicians ($415 billion) and to Medicare Advantage providers ($156 billion). None of the reductions are in benefits. CBO also calculated that the HI payroll tax increase will increase revenues by $318 billion between 2013 and 2022. Thus, the Medicare provisions of the ACA would cut the federal deficit by over a trillion dollars over the next ten years.[58]

Polling

In an April 2015 survey for the Kaiser Family Foundation, 43% of respondents indicated they had a favorable view of the Affordable Care Act whereas 42% expressed an unfavorable impression and 14% were not sure. This represents a continuing improvement in the public's views of the law since July 2014, when opinion was mostly negative (37% favorable, 53% unfavorable). One of the reasons for this negative result no doubt stems from the fact that public awareness of the actual details of the law remains limited. For example, the July 2014 Kaiser poll found that just 37% of the American public were aware that people who got new health insurance under the ACA had a choice between private plans whereas 26% incorrectly thought the newly-insured were enrolled in a single government plan and 38% didn't know. In the April 2015 poll, just 15% reported they had seen quality information about health insurance plans in the past year. In spite of much attention in the Congress toward repealing the law (see below), the Kaiser survey found limited public support for such a course:

- 24% favor expanding the current law:
- 22% support continuing to implement the law in its present form;
- 12% would like to see Congress scale back the law; and
- Just 29% favor repealing it entirely.[59]

In another indication of the lack of awareness about the benefits of the Affordable Care Act, the 2013 Kaiser Women's Health Survey of women ages 18-64 found that such women had an "uneven" awareness of the major provisions of the law. Whereas 74% knew of the individual mandate, and its penalties for those who do not obtain health insurance coverage, just 60% were aware of the requirement for private insurance plans to cover the full cost of at least one preventive or well women visit, 57% knew about the mandate for full-cost coverage of mammograms and pap tests, and only 33% were aware of the prohibition on insurance companies charging women higher premiums than men. Among this survey's other major findings:

- 26% of women (including 16% of women with private insurance, 35% of women with Medicaid and 65% of uninsured women) have had to delay or forego medical care in the past year due to cost, versus 20% of men; and
- 28% of women (including 44% of low-income women and 52% of uninsured women) reported having difficulty in paying medical bills over the past year.[60]

In February-April 2015, the Kaiser Foundation also surveyed individuals who had recently enrolled in non-group health insurance plans, including those who obtained coverage both within and outside the exchanges.

Following the Affordable Care Act's second open enrollment period, most people enrolled in marketplace [i.e. exchange] plans report being satisfied with a wide range of their plan's coverage and features…A large majority (74%) of those in marketplace plans rate their coverage as excellent or good, the survey finds. Most (59%) also say their plan is an excellent or good value for what they pay for it, though the share rating their value as "excellent" declined somewhat from 23 percent last year to 15 percent in the current survey. Majorities also say they are "very" or "somewhat" satisfied with seven different features of their plans, including their choice of primary-care doctors (75%), hospitals (75%) and specialists (64%); what they have to pay out of pocket for doctor visits (73%), prescription drugs (70%), and annual deductible (60%); and their monthly premiums (65%).[61]

Recent actions

1. Congressional votes to repeal, defund or delay the Affordable Care Act. Since gaining a majority in the 2010 elections, House Republicans have (as of February 3, 2015) held 56 votes to repeal, defund or delay all or parts of the Affordable Care Act,[62] the most recent of which was on February 3, 2015 when the House approved H.R. 596, a bill to repeal the law, by a vote of 239-186. (Roll Call #58—Yes: 239 Republicans; No: 183 Democrats, 3 Republicans).[63] None of these efforts have been successful because of opposition in the Senate. The *New York Times* calculated that between assuming control in January 2011 and mid-May 2013, "Republicans have spent no less than 15 percent of their

time on the House floor on repeal [of the Affordable Care Act] in some way."[64] One of the most sustained attempts to repeal the ACA occurred in late September 2013, and was at the center of the dispute that led to a shutdown of the federal government from October 1 through October 16, 2013.

- On September 20, 2013, House Republicans attached a provision to defund the Affordable Care Act to the Continuing Appropriations Resolution (H.J.Res. 59) that would fund the federal government through December 15, 2013. The House approved the measure by a margin of 230-189 (Roll Call #478—Yes: 228 Republicans, 2 Democrats; No: 1 Republican, 188 Democrats), but on September 27, by a vote of 54-44 (Record Vote #208—Yes: 52 Democrats, 2 Independents; No: 44 Republicans), the Senate removed the ACA provision and passed a "clean" continuing resolution providing funding through November 15, 2013.
- On September 29, 2013, the House rejected the Senate resolution, and adopted a new version, after approving amendments to repeal the ACA's tax on medical devices (Roll Call #497—Yes: 231 Republicans, 17 Democrats; No: 174 Democrats) and delay the Affordable Care Act for a year (Roll Call #498—Yes: 229 Republicans, 2 Democrats; No: 2 Republicans, 190 Democrats). The next day, the Senate again rejected the House proposal, voting 54-46 to kill it (Record Vote #210—Yes: 52 Democrats, 2 Independents; No: 46 Republicans).
- On September 30, 2013, the House voted 228-201 (Roll Call #504—Yes: 219 Republicans, 9 Democrats; No: 12 Republicans, 189 Democrats) to adopt a Continuing Resolution that would have delayed the Affordable Care Act's individual mandate (to obtain health insurance or face a penalty) for a year, and eliminated the employer subsidy for health insurance for members of Congress, their staffs, and White House political appointees. Later that day, the Senate killed the House proposal by a 54-46 vote (Record Vote #211—Yes: 52 Democrats, 2 Independents; No: 46 Republicans). With no funding resolution enacted, the federal government shut down at the start of the new fiscal year the next day (October 1, 2013).[65]
- On October 16, 2013, Senate Democratic and Republican leaders reached an agreement to fund federal agencies through January 15, 2014, and raise the debt limit (which by then was in imminent danger of being exceeded, resulting in an unprecedented default by the federal government) through February 7, 2014. All language related to the ACA was removed, except a provision was added to require that the ACA health care exchanges take steps to verify the eligibility of individuals applying for ACA premium tax credits and cost-sharing reductions. On that same day (October 16), the proposal was adopted, first by the Senate by a vote of 81-18 (Record Vote #219—Yes: 52 Democrats, 27 Republicans, 2 Independents; No: 18 Republicans) and then by the House by a vote of 285-144 (Roll Call #550—Yes: 87 Republicans, 198 Democrats; No: 144 Republicans). The government shutdown ended the following day (October 17, 2013).[66]

2. Enrollment. *Exchanges:* On March 10, 2015, HHS announced that just under 11.7 million people had selected a health insurance plan through the federal (8.84 million, or 76%) or state (2.85 million, or 24%) marketplace exchanges in the second open enrollment period from November 15, 2014 through February 15, 2015. Among those signing up through the federal exchanges, 28% were between the ages of 18-34, 54% were women and 87% were eligible to receive federal financial assistance in paying for their premiums. Of those for whom race/ethnicity was reported, 65% were white, 14% were African American and 11% were Latino.[67]

Medicaid: As of March 2015, 12.2 million additional individuals were enrolled in Medicaid and the Children's Health Insurance Program (CHIP) compared to the average monthly enrollment for July-September 2013, a 19.3% increase. Among the states that have adopted the ACA Medicaid expansion, enrollment increased by 26% in this period, compared to an 8% increase in states that have not adopted the expansion. These totals do not include the nearly 950,000 who gained Medicaid coverage through the ACA prior to October 2013.[68] The Kaiser Commission on Medicaid and the Uninsured reported in April 2015 that, "if the 21 states that have not expanded Medicaid as of April 2015 were to do so: the number of nonelderly people enrolled in Medicaid would increase by nearly 7 million, or 40 percent [and] 4.3 million fewer people would be uninsured."[69]

Overall impact of ACA on enrollment. In a May 5, 2015 analysis of "Health Insurance Coverage and the Affordable Care Act," HHS reported that, as of that date:

- 16.4 million uninsured individuals have gained coverage, reducing the uninsured rate from 20.3% to 13.2%, a 35% reduction.
- Among women, an additional 7.7 million adults gained coverage, reducing the uninsured rate from 18.9% to 11.2%.
- Among men, an additional 6.5 million adults gained coverage, reducing the uninsured rate from 21.8% to 15.2%.
- Among African Americans, an additional 2.3 million adults gained coverage, reducing the uninsured rate from 22.4% to 13.2%.
- Among Latinos, an additional 4.2 million adults gained coverage, reducing the uninsured rate from 41.8% to 29.5%.
- Among whites, an additional 6.6 million adults gained coverage, reducing the uninsured rate from 14.3% to 9.0%.[70]

In its March 2015 estimates, CBO projected that, overall, the ACA will result in 17 million more nonelderly individuals having health insurance in 2015 than would have been the case without the law, with the increase rising to 23 million in 2016, 24 million in 2017-2019, and 25 million in 2020 and beyond. (In the latter year, CBO estimated that 23 million would gain coverage through the exchanges and 14 million through the Medicaid/CHIP expansion,

with employer-based coverage dropping by seven million and non-group and other coverage decreasing by four million.)[71]

3. Exchange premium tax credits. Opponents of the Affordable Care Act filed four lawsuits around the country (*Halbig v. Burwell* in Washington, DC; *King v. Burwell* in Virginia; *Pruitt v. Burwell* in Oklahoma; and *Indiana v. IRS* in Indiana) centering on a provision in the ACA stating that the tax credit subsidy for premiums provided through the marketplace exchanges was to be calculated based on the cost of a "qualified health plan…enrolled in through an Exchange established by the State under [section] 1311 of the [ACA]." The plaintiffs (those opposed to the ACA) argued that the provision means that the federal government lacks the authority to provide tax credits for premium assistance to individuals in the states (currently 37) that utilize federally facilitated exchanges. In implementing the law, the IRS determined that, in the overall context of the ACA, it was clear that Congress did not intend for the tax credits to be limited in this fashion, and thus determined that individuals in all states were eligible for the credits, regardless of whether they purchased insurance through the federal or a state exchange. The Obama Administration has vigorously opposed the legal challenges, pointing to a number of other provisions in the ACA that clearly established the equivalency of the federal and state exchanges (including with respect to tax credits). The lead Congressional authors and supporters of the ACA filed a brief with the Courts stating, "Congress did not provide that the tax credits would only be available to citizens whose States set up their own Exchanges. The purpose of the tax credit provision was to facilitate access to affordable insurance through the Exchanges—not, as the Appellants would have it, to incentivize the establishment of state Exchanges above all else, and certainly not to thwart Congress's fundamental purpose of making insurance affordable for all Americans."[72]

On July 22, 2014, a Fourth Circuit Court of Appeals panel in Richmond, VA ruled in *King v. Burwell* that the IRS interpretation allowing tax credits for insurance purchased through the federal exchange was a "permissible construction of the statutory language" and thus upheld those subsidies. However, on the same day a panel of the D.C. Circuit Court of Appeals ruled in favor of the plaintiffs in *Halbig v. Burwell*, finding that a strict reading of the law does not permit tax credits in the case of the federal exchange. The National Women's Law Center had the following comment about the latter ruling.

If this decision is allowed to stand, it would mean 4.7 million individuals—including millions of women and their families—would lose access to affordable health insurance. As the dissent in the D.C. Circuit observed, this case is a "not-so-veiled attempt to gut the Patient Protection and Affordable Care Act." The D.C. Circuit is the only court to find merit in the plaintiffs' thin argument, which many argue is grounded in a drafting error that does not change the meaning of the statute.[73]

An analysis by the Robert Wood Johnson Foundation and the Urban Institute revealed that, should the *Halbig* decision invalidating tax credits for premiums purchased through the federal exchange be sustained, the 7.3 million individuals expected to receive federal subsidies to assist in purchasing insurance coverage through the federal exchange in 2016 would lose a total of $36.1 billion in assistance. Furthermore,

Elimination of the financial subsidies would have a domino effect on other components of the ACA as well: 1. The individual mandate, which requires most Americans to have health insurance coverage or pay a penalty is predicated on the presence of financial support for the purchase of coverage for those who could not otherwise afford it. Eliminating the subsidies means that many more residents of these states would face premium costs in excess of 8 percent of family income, exempting them from the penalties, making coverage unaffordable for many of them, and increasing the number of uninsured. 2. In turn, the regulatory reforms prohibiting insurance companies from discriminating against those with past, current, or anticipated health problems, along with other consumer protections, are predicated on the individual mandate. If almost everyone participates in the insurance pools, all types of individuals can be covered at essentially an overall average price. However, if the pool shrinks appreciably without the subsidies available to draw in many healthy individuals, insurers are likely to advocate strongly for the repeal of these new protections. And they would have a strong case to make.[74]

On September 4, 2014, the full D.C. Court of Appeals canceled the July 13 ruling in *Halbig v. Burwell* and agreed to rehear the case on December 17.[75] However, that rehearing was postponed when the U.S. Supreme Court decided to review the *King v. Burwell* case in its 2014-2015 term beginning in October 2014. Twenty-two states (CA, CT, DE, HI, IL, IA, KY, ME, MD, MA, MS, NH, NM, NY, NC, ND, OR, PA, RI, VT, VA, WA) and the District of Columbia have filed briefs with the Court in support of allowing the premium subsidies to continue whereas seven states (AL, GA, IN, NE, OK, SC, WV) have filed briefs in opposition.[76]

A recent analysis by the Kaiser Family Foundation of the potential impact of a decision overturning the premium subsidies found:

Nationally, 6.4 million people would lose subsidies collectively worth $1.7 billion per month if the Court rules for the challengers. Subsidized enrollees would see an average effective premium increase of 287 percent if they had to pay the full cost of coverage…Florida would be most affected in terms of the number of people losing subsidies (1.3 million), and the total monthly value of those subsidies ($389 million), with Texas ranked second in both categories (832,000 residents losing a total of $206 million per month). When looking at the impact per person, subsidized enrollees in Mississippi fare the worst, with the average enrollee facing an average premium increase of 650 percent if the Court rules for the challengers.[77]

On June 25, 2015, the Supreme Court issued its ruling in *King v. Burwell*. In a 6-to-3 decision, the Court ruled in favor of the Obama Administration in upholding the constitutionality of the ACA's premium subsidies for health insurance purchased through the federal exchange. In the majority decision, Chief Justice Roberts wrote, "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible we must interpret the Act in a way that is consistent with the former, and avoids the latter…The statutory scheme compels us to reject petitioners' interpretation [challenging the law] because it would destabilize the individual insurance market in any state with a federal exchange, and likely create the very 'death spirals' [in insurance coverage] that Congress designed the act to avoid."[78]

4. Exchange premiums. A September 2014 report by the Kaiser Family Foundation found that, based on a preliminary analysis of premium charges for exchange plans for individuals in 15 states and the District of Columbia, premiums were expected to experience only "modest" changes in 2015:

In general, premium changes for 2015 are quite modest when looking at the low-cost insurers in the marketplaces, which is where enrollment is concentrated. On average, the premium for the second-lowest-cost plan is decreasing in the major cities in states with comprehensive public data available. This points to strong competitive forces in the marketplaces, though still a wide range of experiences, with premium changes for the second-lowest-cost silver plan ranging from a low of -15.6% to a high of 8.7%. Since tax credits are keyed to the second-lowest-cost silver plans, this is good news from a budgetary perspective. Our analysis is based on less than one-third of states, and the overall picture could change as more premium data becomes available.[79]

The competitive forces mentioned in the Kaiser study are illustrated by another September 2014 report, this one from the Department of Health and Human Services, indicating that there will be a 25% net increase in the number of insurance issuers offering coverage in the exchanges in 2015 (representing a total of 77 new health insurance issuers in the 44 states for which data is currently available).[80]

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