JOURNAL OF
HEALTH CARE FINANCE

Volume 47, Special Feature 1

Winter 2021

The Affordable Care Act 10 Years After

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

Thoughts on the Affordable Care Act 10 Years After

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Many a good story starts with the line "I received a message from Jim Unland," and that is precisely the case here. Last year, the *Journal of Health Politics, Policy and Law* published an issue focused on the Affordable Care Act (ACA) after 10 years (Oberlander, 2020). Earlier this year David Dillon (2021) published a lengthy article in this *Journal*, describing what has happened in the decade after the passage of the ACA, citing nearly 100 analyses and reports. Still, we wondered if there weren't more thoughts and questions to be answered or posed, particularly among members of the Finance, Economics & Insurance Faculty Forum and the Health Policy Faculty Forum of the Association of University Programs in Health Administration (AUPHA). We convened a conference call with Daniel Gentry, President and CEO of AUPHA, who concurred with the idea, and we were off to the races.

In January 2021 we issued a Call for Submissions: Your Headline Thoughts on ACA and Health Policy. The idea was to solicit top-of-mind thoughts on both (1) The ACA after 10 years after – what worked, what didn't work, what challenges remain, and (2) Healthcare policy priorities for the Biden administration – what new initiatives should be undertaken, what existing things should be changed. We sought short thought pieces on each topic. This isn't the place for long research contributions, which may be inspired by this work and come later. The idea is to have many, varied thoughts presented quickly. With a timeline of only two weeks, we received a dozen acceptable contributions on the topic of the ACA, presented in this Special Feature 1 and half again as many on policy priorities, presented in the accompanying Special Feature 2.

The contributions in this Special Feature cover a broad spectrum of considerations of the ACA. Accessibility and affordability are two important themes. The ACA attempted to both increase the number of persons with insurance and control healthcare spending. Thoughts are mixed on accomplishment of these attempts. The expansion of health information technology, the healthcare workforce and other aspects of the complex healthcare system are explored by the authors. In each Special Feature, contributions are presented in alphabetical order by the first authors last name. No attempts were made to prioritize the contributions.

As Blumenthal, Abrams & Nuzum (2015), noted five years ago "From a historical perspective, 5 years is a very short time, far too short to assess definitively the effects of the ACA." The development of operational rules and regulations took some time after the passage of the ACA, and these are under continuous refinement. Establishing the Marketplace Exchanges took considerable effort, with a number of hiccups along the way. Medicaid Expansion has yet to happen in 11 states, and may never become universal.

The same historical perspective may even apply after 10 years. In his forthcoming book, Jonathan Cohn (2021) writes that the ACA has been altered and challenged many times and "It is also the most ambitious and significant piece of domestic legislation to pass in half a century." Had the results of the 2020 elections been different, many parts of the ACA may have been under further review. And, the courts still have many pending cases that could reshape the ultimate characteristics of the package of health insurance and healthcare reforms that makeup the ACA. Indeed, even at 15 years or beyond, our understanding of the definitive effects of the ACA may not be well understood.

We hope that you find these contributions interesting and that some lead to future investigations and presentations, perhaps even future submissions to the *Journal*.

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Try, Try Again: Can New Account-Based Arrangements Improve Access and Affordability to Private Insurance for Small Firm Workers?

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For 35 million U.S. workers in small firms, employer-sponsored insurance (ESI) access and affordability is a significant concern. In 2008, 61.6% of employees worked at small firms (< 50 workers) that offered health insurance. By 2019, this percentage had eroded to 50.7%. Average premiums for single coverage also increased from $4,501 to $6,920 over this period. In addition to higher premiums, workers also have experienced increased cost-sharing at the point of service, as an increasing share of enrollees face an annual deductible (70.9% to 84.1%) and the average deductible amount has more than doubled (Medical Expenditure Panel Survey, 2021).

To combat the erosion of ESI triggered by the Great Recession, the Affordable Care Act (ACA) included three key changes to the small group market. First, comprehensive regulatory changes were introduced in both the small group and individual market segments in 2014. Key provisions included modified community rating, essential health benefits requirements, actuarial-value based plan standardization, and medical loss ratio regulation. Second, the ACA created the Small Business Health Options Program (SHOP), a parallel Marketplace infrastructure for small employers to shop for and enroll their workers in coverage (Centers for Medicare and Medicaid Services (CMS), 2020). And third, the ACA introduced the Small Business Health Care Tax Credit program to provide time-limited, premium subsidies for lower-wage firms with 25 or fewer full-time equivalent workers purchasing SHOP-based coverage (Internal Revenue Service, 2020).

Many would argue that the impact of the ACA's reforms targeting small group ESI affordability and accessibility have been lackluster at best. Enrollment through SHOP marketplaces has been highly variable across states and over time. In 2017, fewer than 235,000 small firm workers and their dependents were covered through SHOP-based plans and no current information exists to document Small Business Health Care Tax Credit program participation (CMS, 2019a). While employers did not respond to these targeted reforms in ways that policymakers anticipated, the ACA's coverage expansion provisions have contributed to some gains for lower-income, working Americans through Medicaid eligibility expansion and the availability of subsidized coverage in the individual market.

In the post-ACA period, new federal policy solutions that create an explicit link between the group and individual market segments are being deployed to address ESI accessibility and affordability for small firm workers. Specifically, the 21st Century Cures Act passed during the Obama Administration in 2016 included the creation of Qualified Small Employer Health Reimbursement

Arrangements (QSEHRAs). These account-based arrangements permit small employers to provide non-taxed reimbursements for particular healthcare expenses, including premiums and cost-sharing, to employees who purchase individual Marketplace coverage up to a specified maximum benefit cap. In 2019, the Trump Administration expanded the use of account-based arrangements through the creation of Individual Coverage Health Reimbursement Arrangements (ICHRAs) (CMS, 2019b). ICHRAs are distinct from QSEHRAS in that they may be utilized by both small and large employers, they do not have a specific maximum benefit cap, and they create greater flexibility around employer contribution decisions for particular classes of workers. Under both types of arrangements, employees' access to market advance premium tax credits are contingent on whether an employer's contribution is considered 'affordable' as determined by whether the cost of a single coverage silver plan exceeds a given level of household income during the year.

The U.S. Department of Treasury (2019) estimates that these account-based arrangements may be utilized by 800,000 employers and affect approximately 11 million employees and their dependents. As these novel arrangements diffuse, there is much to learn about how they may affect employees' coverage status, financial well-being, and satisfaction as well as employers' experiences with administering health benefits via a defined contribution model. It will also be important to evaluate how these account-based arrangements influence the small group and individual market risk pools. For the Biden Administration, it will be important to consider how future policy actions designed to strengthen the ACA will interact with existing policy mechanisms to encourage ESI accessibility and affordability for small firm workers and their dependents.

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You Get What You Pay for: Creating Financial Incentives to Improve Quality in the Individual Market

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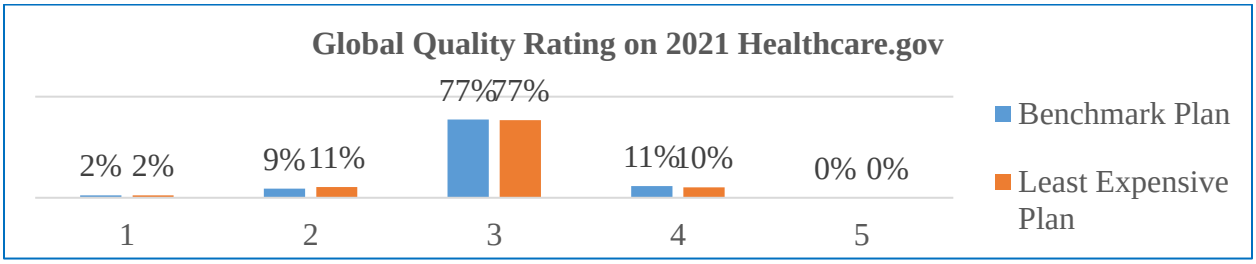
With the goal of expanding coverage to lower-income Americans and those with pre-existing medical conditions, the Affordable Care Act (ACA) significantly altered the regulatory environment of the individual market through the introduction of guaranteed issue and modified community rating. The ACA also made coverage more affordable for millions of Americans through the availability of advance premium tax credits (APTCs) and cost-sharing reduction (CSR) subsidies in newly created Marketplaces. These Marketplaces were established to help consumers more effectively shop for coverage by having comprehensive information on the set of available plans, including cost-sharing attributes, provider networks, plan quality, and premiums.

Today, the Centers for Medicare and Medicaid Services (CMS, 2020a) reports that 87% of Marketplace enrollees receive APTCs and 52% receive CSR benefits. For premium subsidy-eligible enrollees, plans have become more affordable since 2018 with the introduction of "silver-loading" to pay for CSR benefits through increased premiums instead of federal reconciliation payments. Enrollees pay a fixed percentage of their income for the benchmark silver plan. If they purchase a less expensive plan, monthly premiums decrease. Enrollees have the choice of at least one silver plan and potentially other plans for which they can pay lower monthly premiums relative to the benchmark plan. Thus, insurers have strong incentives to design and price their plans in the least expensive way possible in order to attract to price-sensitive enrollees. But what do we know about the quality of the plans that are most affordable for subsidized enrollees?

In 2019, CMS (2020b) began publishing its Quality Rating System (QRS) for incumbent insurers who sell qualified health plans in the individual market. This information includes scores for medical care, member experience, and plan administration which are then rolled up into an overall, global quality rating (GQR). Recent research has shown notable variation by plan characteristics for behavioral health quality (Abraham, et al., 2021) and plan administration scores (Anderson, et al., 2020). CMS hopes this information is used by consumers to make enrollment decisions.

To examine the quality of affordable Marketplace options, we linked the QRS data to the 2021 Landscape Public Use File, which includes the full list of plans offered on Healthcare.gov. We identified the benchmark premium as well as the least expensive plan in each county for the set of counties with incumbent insurers. Among 2,617 counties served by Healthcare.gov, 1,623 had both the benchmark and least expensive plan offered by an insurer with reported quality ratings.

The majority of plans offered at both the benchmark and least expensive price point had a GQR of 3. No plans achieved the highest quality rating of 5. We found particularly concentrated areas of low plan quality in West Virginia, where benchmark and least expensive plans had a GQR of 1, and Wyoming and Montana where every benchmark and least expensive plan had a GQR of 2.



These associations illustrate that affordable plan options for Marketplace consumers are often 'average' at best and sometimes far below average on the dimension of quality. Given that more than four out of five Marketplace enrollees receive APTCs, this implies that federal taxpayers are heavily subsidizing "average" plan quality.

So how might policymakers adapt the price-linked subsidy design to strengthen insurers' incentives to invest in quality improvement and consumers' incentives to choose higher quality plans? One place to look is Medicare Advantage, where insurers that offer four and five star plans receive enhanced federal subsidies and more relaxed marketing and sales rules. New federal legislation could provide consumers with enhanced monthly subsidies to purchase higher quality plans. This design adjustment would provide a clearer economic incentive for insurers to compete on both quality and price instead of merely competing on price.

The ACA has been successful in creating a safety net in the regulated individual market. However, the current subsidy design leads to underinvestment in activities that can improve the quality of care and experiences of enrollees. While the issue of individual market affordability is a priority of the Biden Administration, policymakers should also recognize that all health plans are not created equal and that value is a function of both cost and quality dimensions.

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ACA Medicaid Expansion Effects on Healthcare Costs

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The Patient Protection and Affordable Care Act (ACA) of 2010 was designed to reduce uninsurance rates and address a dwindling Medicare Trust fund and chronic medical cost inflation. Prominent among the Act's many provisions was states' expansion of their Medicaid programs. Ultimately, the Supreme Court decided that states could optionally expand Medicaid with no penalties. As of early 2021, 38 states and Washington DC expanded their programs consistent with the ACA or other established mechanisms, such as through 1115 waivers.

While research first established that Medicaid Expansion significantly reduced the number of uninsured, subsequent studies also examined the effects on cost inflation. Medicaid Expansion can impact costs from the perspective of numerous stakeholders including (1) Medicaid enrollees, (2) healthcare delivery organizations, and (3) Medicaid programs as state agencies. Herein we summarize the contemporary financial effects of Medicaid Expansion on these three groups and comment on remaining challenges and anticipated policy changes under the Biden administration.

Obtaining health insurance could reduce stress and the financial burden of costly care on enrollees. Studies show that Medicaid Expansion resulted in stress reductions among newly eligible individuals, decreased out-of-pocket expenditures, and significantly reduced the use of predatory 'payday' loans, which are typically used by those facing dire financial situations. Medicaid Expansion also increased the likelihood of receipt of child support payments - likely due to improved financial stability for paying parents, and improving the financial stability of recipients.

Hospitals experienced improvements in financial performance. Researchers observed reductions in uncompensated care and increases in Medicaid revenue among hospitals in expansion states. Medicaid Expansion also improved hospital operating margins and reduced hospital closures, especially in rural areas or locations with high uninsured populations prior to expansion.

As intended, Medicaid Expansion increased federal spending which shielded states from higher costs or crowd-out of other state expenditures such as education or transportation. Some evidence even suggests that individual states experienced savings as a result of expansion. Moreover, expansion appears to have not adversely affected administrative costs, and in some cases improved administrative efficiencies.

Despite these documented benefits, questions about the impact of Medicaid Expansion on finances remain. Concerns have been raised that some expansions implemented via 1115 waivers have not been rigorously evaluated as required by law. As the priorities of different presidential administrations shifted, waivers gained approval based upon new criteria. As such, the effects of expansions that augmented eligibility, enrollment processes, covered services, and state oversight warrant further research. Moreover, the use of Medicaid managed care has increased to 70% nationally in 2018. This trend has the potential to improve various aspects of Medicaid, but thus far little research has examined how this shift has affected overall healthcare costs or the administrative expenditures of managed care entities.

Further, while the federal government initially covered 100% of the costs for those newly eligible under Medicaid Expansion, states began assuming phased-in responsibility for costs beginning in 2016. It is unknown how this shift has affected either state or federal finances, or state-level programmatic changes. Lastly, the pandemic has greatly increased Medicaid enrollment due to the ensuing economic downturn. Given Medicaid's role in providing access to care including COVID-19 testing, acute care services, vaccinations, and education, more research is needed to understand how Medicaid expansion mitigated the ill effects of the pandemic on state economic and health outcomes.

As the Biden administration begins its term, changing priorities in Medicaid could be expected. We anticipate seeing pressure on holdout states to expand Medicaid and deliberate federal emphasis on further reducing the number of uninsured especially via Medicaid in lieu of other mechanisms. We may also see efforts to reevaluate the priorities of the previous administration regarding the use of restrictive Medicaid provisions (e.g., work requirements), the restoration of retroactive eligibility, which posed a barrier to coverage and increased administrative burdens, and a reexamination of the block funding approach recently implemented.

Today, Medicaid provides health insurance to more than 75 million Americans. Many policymakers are interested in strengthening the program consistent with its original purpose. In the decade since the ACA became law, research has documented how Medicaid Expansion played a critical role in the financial stability of vulnerable populations, improved the bottom line for healthcare delivery organizations, and has buffered state government against cuts to other programs.

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The National Health Care Workforce Commission of the ACA — Failure to Launch

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As we reflect on the Affordable Care Act (ACA), a significant lost opportunity provided by section 5101 of the Act was the National Health Care Workforce Commission. The Workforce Commission was charged to provide Congress and the Administration(s) with data on the health care workforce and policy advice. These reasonable tasks parallel those of other past federal commissions such as the Physician Payment Review Commission that led to the adoption of the Resource-Based Relative Value Scale (RBRVS) system for physician payment through the Centers for Medicare and Medicaid Services (Lee et al., 1989).

Sadly, this charge was never implemented despite the appointment in 2010 of the initial members of the Workforce Commission. The $3 million requested by the Obama administration were never appropriated to support the work of the Workforce Commission. As political controversy and legal challenges threatened the existence of ACA itself, the Workforce Commission became a sad footnote to the history of the Act. The duty to plan has not been fulfilled and leaves critical policy areas unaddressed.

Work force planning has been a Balkanized enterprise in the United States at best with major policy roles left to professional societies and educational institutions. Issues that could be considered are numerous and pressing.

A prime example of failure to conduct work force planning is the maldistribution of primary care physicians vs. specialists in the physician workforce. As Robert Wood Johnson Foundation CEO Steven Schroeder observed in 1987, the U.S. has an “inverted pyramid” of one-third primary care physicians underpinning two thirds specialists. While policy interventions have been created to incentivize entry into primary care through grant support and debt forgiveness for individuals, a comprehensive strategy remains elusive.

A renewed and overdue concern is that of racial and ethnic diversity in the ranks of health professionals. Research has consistently concluded that minority and underserved persons respond more favorably to caregivers of their own identification based on the cultural competency of these providers. The Association of American Medical Colleges campaign goal of the late 1990’s of 3000 minority enrollees in U.S. Medical Schools by the year 2000 was not achieved, and to this day remains an unrealized objective. At present, approximately 2,500 new enrollees are African American, Hispanic/Latinx, or Native American although the number of medical school slots has

increased from 18,000 in 2000 to 21,000 today. In the absence of a coordinated national strategy, efforts to redress this shortfall are left to individual states, universities and philanthropists, such as Michael Bloomberg's $100 million gift to the four minority serving schools of medicine. Gender distribution has improved during this time, with women accounting for the majority of medical students for the first time in 2019.

Our nation's reliance on professionals trained outside the U.S. continues, accounting for 25% of all practicing physicians. Dentists trained abroad are 24%, pharmacists 20%, and registered nurses 16%. This structural dependence deprives countries of origin of valuable skills in dealing with an undeniably globalized health environment in which viruses respect no boundaries. Yet the Migration Policy Institute reports that 165,000 foreign trained health professionals are in the U.S. but are unemployed or underemployed based on their training (Batalova, 2020). It has been suggested that these professionals be granted emergency privileges in the COVID19 pandemic, and 5 states have done so. While this may address a U.S. need, it also makes nations of origin of these persons vulnerable to a global pandemic.

Our peculiar system of financing graduate medical education also contributes to the list of unaddressed health challenges. The predominant source of funding for this training is not the education system, but rather revenues derived from patient care payment systems (primarily Medicare and Medicaid) at sponsoring health care provider organizations. The formula set in place in the Balanced Budget Amendments of 1997 provides for funded slots equal to that year's medical graduates plus 10%. This has not been adjusted upward despite the addition of new medical schools and encouragement of the American Association of Medical Colleges (AAMC) to increase class sizes by 15%. The AAMC has lobbied for 15,000 new residency slots to address this issue.

In conclusion, the current COVID19 pandemic has exposed deficits in our health workforce that might have been planned for through a functioning workforce commission. The AAMC projects a shortfall of 122,000 physicians by 2032, and similar shortages are foreseen in other professions as both the current workforce and the population it serves ages. A cohesive workforce policy is an unfulfilled legacy of the first decade of the ACA, and deserves to be revitalized by the Biden Administration.

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Ten Years of Health Information Technology Policy and Progress? The ACA Effects

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The Patient Protection and Affordable Care Act (ACA) directly sought to reduce healthcare costs and improve care quality by mandating federal policies that increased efficiency. One of the primary tools that was envisioned to bring about substantial change was the further incorporation of health information technologies (HITs) into the sector. The underlying belief was that improved health information availability would allow providers and patients to make decisions that were both more efficacious and cost-effective. Section 4103 of the ACA directly stated:

> *(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries. (ACA, p. 555)*

However, the ACA, other legislation from the period (e.g., Health Information Technology for Economic and Clinical Health Act of 2009), and subsequent laws (e.g., The 21st Century Cures Act – 2016) have all fallen short of the envisioned system of interoperable health information technologies needed to improve quality and increase cost effectiveness. To date, three main issues continue to limit the potential gains from health information technology – interoperability, consumer engagement, and innovation.

First, interoperability was not clearly defined ex ante implementation of the PPACA. While some data standards did exist, such as HL7 (i.e. an international standard for transfer of health data), they did not ensure that systems would be able to meaningfully exchange data. Competing HIT system providers sought to restrict the ability of others to access their data by claiming it would increase the likelihood of HIPPA violations. Furthermore, an alternative view HIT service providers argued is that the health data could be monetized in other ways, and openly sharing it would be forfeiting lucrative revenue streams.

One solution to the interoperability issue was to create data repositories at the state or local level.

However, this solution requires ongoing funding of a governmental or quasi-governmental organization. Few politicians had an appetite for creating another ongoing cost center. Another solution would be to have a law or regulation that mandated every health information system had an application programming interface (API) that other parties could plug into. To date, the HIT vendors' lobby has successfully resisted this type of interface, citing prohibitively high cost of development and maintenance. The success of efforts to increase interoperability and health information exchange will directly affect the ability to improve care coordination and reduce the concomitant cost associated with the lack thereof.

The second major hurdle to realizing the PPACA's vision of improved care through HIT is inadequate gains in consumer engagement. One of the major elements designed to address both care cost and quality was increased consumer engagement. In particular, the personal health record was intended to provide patients with the information needed to manage their own health. Moreover, it was hoped that patients would engage providers making shared medical decisions that took into account the cost of care. The empowered consumer has yet to emerge, but there are ongoing efforts to increase price transparency and provide consumers with actionable information.

The last major issue that federal legislation has had on HIT is to slow, rather than accelerate innovation. In particular, the requirement that HITs, such as the electronic health record (EHR), be 'certified' increases barriers to new product entry. Additionally, given the scope and complexity of an EHR, it was difficult for many legacy systems to meet new rigorous certification standards, and the market has shrunk to a small number of major firms. Moreover, the cost of switching EHR vendors is sufficiently high and cumbersome for health systems. As a result, most health systems are disinclined to switch to different vendors. Thus, in turn, existing EHR firms have little to no incentive to innovate in order to drive growth in their market share beyond the margins.

Overall, federal legislation, such as the ACA, has had mixed results on HIT adoption and implementation. On the one hand, it has ensured that most providers (i.e., hospitals and physicians) use some form of EHR to capture patients' health information and granted patients the opportunity to interact with the data. Also, it led to changes in the competitive landscape for HIT vendors. On the other hand, it is equally likely that providers would have adopted and consumers would have engaged with HITs freely in their own right. Further, it is still questionable how much more (or less) incentives HIT vendors would have had to compete on the cost and quality of their systems absent any mandates in the first place. Hopefully, this new decade will produce substantial gains in terms of interoperability, consumer engagement, and innovation for beneficiaries using health information technologies."

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

The Affordable Care Act: Opportunity Defies Challenges

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Three little words – Affordable Care Act (ACA) – led to an important, unintended outcome of three, not so little, words – Population Health Management (PHM). The ACA, often compared to the 1960s legislation that produced the entitlement giants of Medicare and Medicaid, continues to define the healthcare sector more than 10 years after its initial passage. From within the 1200+ page document, a community of health leaders envisioned opportunity and innovation that eventually led from the traditional medical model and fee-for-service paradigm to the population-based, collaborative risk financial model in its nascent stages today. The ACA is so much more than a catalyst for Accountable Care Organizations and Medical Centered Homes models and their accompanying alternative payment structures. It is a health policy shift capable of amazing transformations fueled by the 21st century drivers of change – rapid technological and clinical advances. Why did population health management emerge? From the moment ACA pivoted from an individual exchange model system of supply and demand, to one that offered flexibility and opportunity for risk incentives based on health outcomes, the health policy perspective transformed. PHM envisioned and provided a new administrative infrastructure that enabled ACA innovations, approaches, and strategies to emerge.

Rather than itemize a list of ACA influenced projects and initiatives, the following points summarize the achievements through a PHM lens. Each of these five, disparate outcomes highlights reflect an ACA-inspired impact.

- The Dream Weaver Spell refers to the ACA's mandate for each hospital to complete a Community Health Needs Assessment with local public health input. Imagine aligning the public health safety net resources with health systems strategic plans. Would cooperation and collaboration lead to PHM's vision of the co-production of health? Should other non-traditional collaborators and/or competitors, perhaps even for-profit entities, be considered?

- The Technology Nudge began prior to the ACA propelled by the meaningful use requirements for Electronic Health Records. The nudge yielded a return on investment via the integration of data analytics' tools such as predictive modeling and the untapped potential of artificial intelligence for health sector analysis.

- The Indisputable Financial Disruptor known as "risk" rudely challenged all health sector stakeholders including payers (private and public), health sector organizations (commercial insurance), health care providers and practitioners, and hospitals/health systems. Accountable Care Organizations and Patient Centered Medical Home alternative payment models did not

exist before the ACA. Will the new norm include the traditional fee-for-service, or will the health finance transformation continue to a full-risk, upstream and downstream model?

- The Expanding Continuum of Care, an unanticipated ACA outcome, addressed the rapid rise of consumerism. In the consumer's eyes, value did not equate with the simple equation:

  Value = (Quality x Risk/Severity Adjustment) ÷ Cost of Care.

  The consumer's quest for convenient options led to expansions in types of care, locations, hours, and use of health providers in non-traditional settings. PHM relentlessly continued searching for improved access of care, increased quality and lower costs.

- Balancing the Equity vs. Equality Seesaw occurred because of the individual health insurance mandate (now defunct) that effectively questioned the status quo between the uninsured and insured health markets. The expanded Medicaid programs enrolled individuals previously without risk protection against health crises, but with health outcomes impacted by the social determinants of health (SDOH). Today, the federal government's COVID-19 distribution plan specifies the use of a Social Vulnerability Index (National Academies, 2020).

Was the ACA a success or failure? Rating each of the achievements discussed would yield mixed results. Regardless of whether you label the ACA as a transformation, paradigm shift, game changer, or disruptor, this health policy continues to define the state of the healthcare sector today. Will the PHM tent continue to be broad and inclusive enough to capture both universal health and the competitive capitalism of health care stakeholders? Will the mega health systems, spurred on by venture capitalists, create new health entities that dwarf the ideas of the short-lived Haven model (Gamble, 2020)? Will health providers, consumers, or employers design a more marketable and sustainable tent or become a side show?

Rosenbaum (2011) described the ACA as a "watershed in US public health policy." Perhaps, the statement should be amended to "a watershed in US population health policy."

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

Affordable Care Act Affordability

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The Affordable Care Act (ACA) has been a controversial healthcare policy. The ACA federally mandates that states follow guidelines meant to increase healthcare access to targeted groups of the population. One of the greatest barriers preventing people from receiving healthcare can be cost. A person without health insurance may be faced with the decision to fund medical treatment at the literal expense of their living arrangements. Conversely, an individual may not even have a choice in receiving treatment if finances are not accessible. The cost of healthcare is a barrier for treating illnesses and serves as a challenge for some to receive preventative healthcare. The ACA was an attempt to mitigate some of the financial burdens of healthcare.

Barriers to preventive health care could be a lack of health care coverage, lack of fiscal means, or even proximity to their specific health care needs. The ACA has attempted to address those barriers by increasing access to health insurance for targeted populations as well as expanding to individuals with special healthcare needs--individuals of the population who have preexisting conditions. What this means is that prior to ACA, if an individual had a chronic illness, then an insurance company could either refuse to pay medical providers or pharmacies who help manage the condition. The insurance companies could also charge higher insurance rates for individuals with preexisting conditions without the mandates of the ACA. Eliminating the preexisting condition factor expanded treatment options to for those who may have been unable to afford treatments.

Another targeted group who benefited from the ACA are emerging adolescents under the age of twenty-six. The ACA allows adolescents to be classified as dependents within the scope of their caregivers or parents' medical insurances, which allowed that group to continue to have access to healthcare if their parents had it. This addition to the ACA helps adolescents who are transitioning into adulthood to maintain healthcare coverage and serves as a transition period for young adults who have yet to find a profession that provides them with health care coverage and as such prevents young adults from experiencing incredible debts related to a catastrophic health care event.

A great failure that has since been revoked was financially penalizing those who could not otherwise afford health insurance. While there were financial penalties to employers who did not provide health insurance to employees, there were loopholes that some business exploited. For example, if a business only allowed an employee to work less than full-time hours, then they would not be required to provide health insurance. Those employees not only had the financial burden of losing out on fulltime status, but they were then taxed with an additional penalty. Not having the foresight to close legal loop-holes which would allow big businesses to save on the bottom line of

their health care cost hurt the very people the ACA attempted to help, and those same people's confidence in the ACA.

While the ACA did well with alleviating some financial barriers to healthcare, future healthcare policies should continue trying to mitigate health disparities. Healthcare is strongly linked to socioeconomic status, and healthcare is seen as a commodity for those who can afford it. Policies moving forward should explicitly address how the financial costs of healthcare Policies moving forward should explicitly address how the financial costs of healthcare are literally costing people their lives.

JOURNAL OF HEALTH CARE FINANCE

VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

Colorectal Cancer Screening in Louisiana after Medicaid Expansion: A Call to Increase Reimbursement Rates to Avoid Being Functionally Underinsured

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The 2010 Patient Protection and Affordable Care Act (ACA) has led to improvements in the United States health system. From prevention focused policies to a state's ability to expand Medicaid programs to include adults earning incomes 138% of the federal poverty level, the healthcare landscape has shifted to ensure more Americans access to comprehensive healthcare. Louisiana is one of 39 states that adopted Medicaid expansion, and continues to be one of the few Southern states leading the charge with adoption of this program.

Since the Louisiana's implementation of Medicaid Expansion in June 2016, uninsured rates have been cut in half (16.6% in 2013 to 8.9% in 2019) (United Health Foundation, 2021). Nearly 600,000 adult residents now have healthcare coverage (Louisiana Department of Health, 2021). As Louisiana rounds its fifth year of Medicaid Expansion, beneficial impacts are being felt in colorectal cancer screening. Colorectal cancer is one of the deadliest, yet most preventable cancers. Louisiana has increased its screening rates by 5 percentage points (64.2% in 2014 to 69.3% in 2018) (Centers for Disease Control and Prevention, 2018) and decreased its state ranking for colorectal cancer deaths from third to fifth. Over the Medicaid expansion period, timely screenings and removal of pre-cancerous colon polyps has saved over 17,000 Louisianans from experiencing a colorectal cancer diagnosis.

Nine months post-implementation of Medicaid Expansion (April 2017), the Louisiana Colorectal Cancer Roundtable (LCCRT) conducted a survey to assess the acceptance of Medicaid and the knowledge of Medicaid Expansion among colonoscopy providers throughout Louisiana. (Kaufman, 2017). The survey was sent to 150 members of the Louisiana Gastroenterology Society. With a response rate of 35%, the survey revealed that 27% of colonoscopy providers were unaware that Medicaid Expansion had occurred in Louisiana. These results imply an acute need to ensure providers are informed of and involved in major healthcare policy changes. Not doing so undermines the goals of policies, including the ACA, to improve access to care, especially with respect to populations most in need of care.

Survey results also indicated that only 42% of colonoscopy providers accepted Medicaid. The most common reason for non-acceptance was low fees. Medicaid fees to physicians tend to be less than two-thirds of what Medicare and private insurers pay for the same services. In Louisiana, Medicaid fees are only 70% of Medicare fees. As a result, large areas of the state, particularly central and southwest Louisiana, including many rural areas, did not have access to colonoscopy services.

Understanding that low Medicaid fees may inhibit expansion adoption among states and providers alike, the ACA mandated and supplied federal funding to increase Medicaid fees for primary care services to Medicare fee levels. This was known as the "fee bump" and lasted 2 years (2013-2014). While the total effects of this financial incentive are mixed, higher Medicaid fees increased access to primary care services (Saulsberry, Seo & Fung, 2019). Specialty providers were excluded from the incentive, but similar effects could be anticipated for access to colonoscopy providers. Policymakers should revisit the "fee bump" to address low, and often unfavorable, Medicaid fees.

Furthermore, being insured is just the first step in accessing healthcare for many Louisianans. Medicaid beneficiaries continue to encounter barriers, such as transportation and time off work, when accessing colorectal cancer screening. Louisiana still sees low screening rates among low-income individuals, and even starker disparities with higher colorectal cancer cases and deaths among Black men than other groups. There is a striking lack of Medicaid practitioners that provide colonoscopy services in large areas of the state, which can compound access disparities.

The ACA Medicaid Expansion short falls experienced in Louisiana do not outweigh its benefits. It's essential to build on the momentum the ACA has created to improve healthcare access and outcomes in the United States. To ensure Louisiana, and other states, can sustain coverage and access improvements following Medicaid Expansion, federal policy makers should consider targeted legislative strategies that make Medicaid an attractive option for states, such as boosting federal financial matching and incentives. Doing so will ensure that gains seen in healthcare access, cancer screenings, and diagnoses are maintained for years to come. Such strategies can help ensure that Medicaid beneficiaries have the same access to full healthcare services afforded to their private payer and Medicare counterparts, as opposed to remaining functionally underinsured.

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

The Unaffordable, Affordable Care Act

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Policymakers in the United States focus on the millions of Americans without health insurance as the significant driver of health problems. Their solution to the growing problem of access to the health care system and rising health care costs culminated with the enactment of the Affordable Care Act (ACA). While the initial impact of the ACA increased the number of Americans with health insurance coverage, it has fallen short on making that coverage affordable and providing a solution to our country's underlying health care struggles. We consider three key issues: ineffective penalties, insurance does not guarantee access and the prevention model,

Ineffective Penalties. The risk of penalty under the individual mandate was intended to drive people to the insurance market, hoping for affordable coverage. The expanded Medicaid eligibility and government subsidies to purchase insurance through the ACA exchanges further provided healthcare coverage to millions of lower-income individuals who otherwise would remain uninsured. However, even those eligible for government subsidies to cover premiums were still left with sizable deductibles, copays, and coinsurance. Many individuals with incomes too high to qualify for government subsidy and with average health risks found it cheaper to pay the penalty than purchase overpriced coverage. The eventual repeal of the individual mandate penalty further drove the exodus of healthier individuals out of the marketplace and contributed to higher market premiums for those who remained.

Insurance Does Not Guarantee Access. Even if one has insurance coverage, it does not solve the country's health equity issues. Accessing health care remains a challenge. A narrow network hampers those on Medicaid. Low reimbursement rates result in many physicians not accepting or limiting the number of Medicaid patients they see.

Racial disparities also exist because physicians are significantly less likely to accept Medicaid in areas with higher racial segregation levels than are physicians in other areas. Some larger academic medical centers maintain separate and unequal clinics for Medicaid and private insurance members and often provide a low tier of care. Issues related to provider-patient trust and discrimination in these communities also leads to worse health outcomes and increased healthcare costs.

Individuals who purchase insurance directly from the exchange may also be challenged to find providers that accept this insurance. Because the provider must collect a higher out-of-pocket cost from the patient and the insurance coverage can be dropped for failure to pay premiums, the risk of paying for care shifts from insurers to providers and patients. This risk-shifting has scared many providers from accepting or limiting the number of patients they see who have individual coverage through the exchange.

Even if an insured person can find a provider who will see them, many face transportation issues and the dilemma of whether to receive care or miss hours of work without pay. The bottom line is that having insurance does not guarantee access to health care services and will not solve the healthcare crisis in this country.

The Prevention Model. Health happens in the communities that people live in and interact with, shaping individual and population-level behaviors. Investing in social policies that promote equity in education, housing, environmental, and employment opportunities are critical steps toward improving health outcomes. Creating community-based health care services, such as medical homes outlined in the ACA, provide chronic care management and preventative services that are more likely to represent the actual needs of those living in the community. Improving chronic care management will significantly lower health care costs and alleviate inefficient health care utilization by patients with complex health needs.

Even though the ACA is not a perfect plan, it has set the fundamental groundwork for future health care progress in the United States. As each political party brings its healthcare agenda forward, the changes come at the American people's expense.

If we want to reduce socio-economic, racial, and ethnic health disparities, we as a nation have to embrace this challenge with a unified, bipartisan front to address and finance social determinants of health. We argue that there is a need to offer prevention initiatives outside of the costly insurance-driven system. Otherwise, all good intentions will not lead to affordable health care.

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

Health Care Policy Priorities for 2021 and Beyond

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It has been over 10 years, along with much controversy, since the Affordable Care Act (ACA) was signed into law to begin the reformation of the US Health Care System. The debate continues. As with most changes, there are positives and negatives, and depending on who and where the discussion takes place, there are numerous viewpoints. The deliberations between partisan lines continue, and the path forward remains uncertain, but what we can acknowledge is the opportunity to improve our health care systems.

The ACA was set out to provide access to insurance coverage for all, increasing consumer protection, promoting prevention and wellness, and improving quality, all while reducing health care cost. As imagined, these deliverables have had its challenges.

It is important to highlight that a principal provision of ACA was to provide everyone the access to insurance coverage. Currently, more individuals have coverage than before. Not only do more Americans have access to insurance, the ACA takes satisfaction in promoting prevention and wellness, along with encouraging community engagement. In many instances, Americans can now receive coverage through their employer, mainly if the employer has 50 or more employees. Additionally, individuals may qualify to purchase plans through the health care exchange and receive subsidies to lower the cost of premiums. Better yet, an individual cannot be denied coverage for a pre-existing condition, which had been a financial burdened for many individuals in the past. Another monumental provision is the ability for dependents to stay under their parents' plan until they are 26 years old. This has allowed for those individuals not meeting full-time student criteria and without employer coverage to have access to insurance. However, the most notable provision has been the expansion of Medicaid, which covers uninsured Americans falling under the 138% poverty level. There have been 34 states plus the District of Columbia that have adopted the Medicaid Expansion. The states adopting the expansion through their standard legislative process have allowed an additional 14 million to receive healthcare coverage, plus they have directly had a positive impact for health providers.

The ACA has had its challenges, from the consumer and employer to the provider. The consumer unable to qualifying for subsides could potentially spend more dollars under the ACA. Individuals not qualifying for subsides were unable to purchase insurance or participate in one of the marketplace plans, thus making it unaffordable, with an imposed penalty prior to 2019. Americans have also been dissatisfied with the provider options and do not have an incentive to switch to the exchange since it costs more and will have to change providers. However, the positive is that most employers providing insurance to their employees are able to receive a tax credit; moreover, they demonstrate the value placed on their employees' well-being by offering coverage. Employers

recognize the expense of providing employees insurance coverage is expensive, but there is a burden to adhere to laborious regulations, staffing, and other associated costs. From the provider perspective, the challenges have been many, but more so, how do we navigate the future and stay whole?

Healthcare is the definition of change and providers must stay vigilant and meet the challenges. How do we combat an increase in cost share, the ability to provide adequate consumer information, and the need for greater transparency that will play out in the post COVID-19 economy?

In reflection, the realization we have a healthcare system in need of a transfiguration is a move forward. The ACA, imperfect in many areas, has provided more Americans access to coverage and health care.

The challenges facing us now are how to build on the ACA towards decreasing cost, and how to navigate the health system, increase consumer choices, drug prices, cost transparency, Medicaid expansion in the 14 remaining states, and employer tax credits. These are a few areas needing enhancement.

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

How the Pandemic Drove Innovation More Quickly Than the ACA

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The Affordable Care Act (ACA) has remained in the news and been passionately debated since it was passed by Congress and signed into law. There have been numerous articles about whether or not it accomplished the initial goals set out by President Obama and his team, including a reflection by President Obama himself on the achievements of the legislation (Obama, 2016). Rather than replay the debates about if and how the legislation improved access, reduced costs and improved quality, I want to focus on whether it has driven innovation over the past 10 years and what more can be done to accelerate innovation moving forward.

Had this opinion piece been written over a year ago, I might have had a different perspective on the ACA's impact on innovation. I would have celebrated the success of the incremental progress made in value-based reimbursement and patient-centered care. But when you look at the amount of innovation that occurred over the past 10 years versus the healthcare innovation adopted just in the past year, the perception of results delivered by the ACA changes.

Health care generally has been slow to change and disruptive innovations have been few and far between. The recent closure of Haven Health is just one example of the difficulties of disruptive change. The fragmented health system structure, the complex regulatory requirements and the misaligned (and sometimes perverse) reimbursement incentives have proven to be significant barriers.

The COVID-19 pandemic created the urgency, in Kotter speak, that is the foundation of successful change management (Kotter, 1996). The Affordable Care Act prodded healthcare to change; the pandemic demanded it. The rapid adoption of telemedicine in a one-year timeframe is a great example of disruptive change. The key barriers that have historically stalled this type of disruptive innovation – Medicare and private payer reimbursement, state regulations on medical practice and consumer resistance to change - were rapidly resolved to facilitate rollout and implementation very quickly. And with the genii out of the bottle, it will be impossible to reduce and/or eliminate the telemedicine care option.

I know that the pandemic created an unusual situation, and I am not suggesting that a life altering event is required to transform healthcare. But there are lessons to be learned that can accelerate disruptive innovation in healthcare.

First, the complex reimbursement structure has been and continues to be a major barrier to change. The structure was developed during a different time and reimbursement has not kept current with advances in technology and changes in care delivery. For example, telemedicine, a valuable alternative to physical visits, was reimbursed at lower rates than physical visits, if reimbursed at all. As a result, health systems and clinicians were slow to adopt it. In another example of technology outpacing reimbursement, tasks performed by artificial intelligence do not fit the current reimbursement structure. Innovation is delayed, and in some cases killed, by a reimbursement structure that is very difficult to change, requires long lead times to adjust and is overseen by stakeholders that may be threatened by the disruptive change.

Second, the regulatory environment makes innovation difficult. For example, the split of responsibilities between state and federal authorities can be a barrier to rapid national change. As seen in the telemedicine example, state medical licensing regulations had to be bypassed so that physicians licensed in one state were allowed to see patients virtually in another state. Again, the regulatory environment was built for a physical healthcare environment and is not fit for purpose in today's technological world.

Finally, with younger generations growing up in a technologically enabled world, there is increasing demand for healthcare to adopt service models akin to modern successful organizations, such as Amazon. The pandemic took down barriers that have traditionally thwarted disruptive innovation in healthcare; telemedicine companies, that had worked long and hard to push adoption, became overnight successes. And traditional health systems were forced to pivot and develop a telemedicine capability.

I encourage us to take the lessons from the pandemic on busting barriers to innovation and continue to disrupt and improve our healthcare system. The risk we face is the natural tendency to return to the world as we knew it. The stakeholders that collaborated so successfully during the pandemic – state and federal governments, private payers, health system management and clinicians, technology companies – should continue to collaborate We don't need a pandemic (or the Affordable Care Act) to disrupt the healthcare system, we should do it because it is the right thing to do.

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VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

The Affordable Care Act in a Complex System

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What the Affordable Care Act (ACA) sought to accomplish was to increase the number of people who would be covered by affordable health insurance and by doing so the health and health care to previously underserved populations would be improved. At the same time, ACA sought to develop and implement strategies to control costs and promote overall population health, with an emphasis on wellness and prevention.

At the time of its passage (2010), the uninsured rate in the nation was approximately 17.8%. It was significantly reduced to approximately 10.0% by 2016 for the nonelderly population. Since that time the percentage of uninsured has been on the slow rise (Tolbert, Orger & Damico, 2020). While the percent of uninsured declined, the majority of those newly insured resulted from the expansion of financial eligibility for Medicaid. While certainly an improvement from being uninsured, the expansion of those covered by Medicaid, provided insurance with limited access to many providers. There has been an unwillingness for many in private practice to accept patients with Medicaid due to low reimbursement rates, thereby perpetuating a two-class system of care, in which the poor obtain their care much more so from institutional providers, e.g. clinics and federally qualified health centers. Significant health disparities remain for the poor and minorities with Medicaid, compared to those with more universally accepted forms of insurance.

The ACA did not change the complexity of the health insurance system. There is still Medicare and Medicaid and Veterans health insurance, CHIP, Workers Compensation etc. There is still a reliance for those not covered by government-sponsored plans for employment-based health insurance through for the most part for-profit insurers, adding to the costs of goods and services. Many who are covered by government-sponsored programs, obtain their "managed" services through a for-profit insurer, under contract with that government agency.

For those not covered through any of the usual means and must use some form of ACA "Exchanges" the cost of health insurance premiums can be very daunting in terms of affordability. Annual, unsubsidized family rates for one "Silver Plan" for first quarter 2021 are approximately $21,600 with an $8,600 deductible and a maximum out-of-pocket expenditure of $16,300 (Healthfirst, 2020). A family of four, earning more than $103,000 is no longer eligible for premium subsidies. Is the cost of premiums plus maximum out-of-pocket expenses of $37,900 really therefore affordable?

Insurer profits are realized by minimizing what the industry calls their medical loss ratio, i.e. what they pay out in claims versus their premiums. In recent years, payouts in relation to premiums have declined. Insurance premiums continue to rise, with continued government subsidies for premiums while profits for many insurers continued to rise.

Yes, there has been movement toward cost-increase moderation and change in health care and health insurance models toward improved quality, e.g. Accountable Care Organizations and Patient Centered Medical Homes, Value Base Purchasing (Reimbursement). However, fee-for-service reimbursement still dominates, whereby the more care that is provided the more the provider earns. Many have attributed its dominance as a major cause for health care cost increases. "Sick care", as opposed to population health and wellness still appears to be the dominant focus of care. Concurrent with fee-for-service has been various models of capitation, where the insurer's net income is enhanced by providing less services and less expensive services. Some have questioned priorities of profits versus the provision of quality of care. And there also remains an "alphabet soup" of managed care models.

The challenges are many. How can disparate access to care, disparate quality and resultant disparate health outcomes be reduced and some day (hopefully) eliminated? Can evidence-based medicine effectively assist to achieve an acceptable balance of cost and quality? Is there an implementable model for shifting the health care system to population health and wellness? Toward that end is there an implementable pathway to reverse the ratio of specialty care to primary health care providers.

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JOURNAL OF HEALTH CARE FINANCE

VOL. 47 (SPECIAL FEATURE 1), WINTER 2021

The Affordable Care Act and Value-Based Insurance Design

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The Patient Protection and Affordable Care Act (ACA) though often labeled "healthcare" reform is perhaps more appropriately labeled "health insurance" reform. The ACA removed barriers to traditional insurance coverage (e.g. nondiscrimination on the basis of pre-existing conditions, extension of dependent coverage) and provided new avenues for obtaining health insurance coverage (e.g. marketplaces and Medicaid Expansion). Health insurance is an important perquisite for receipt of many healthcare services is the United State, yet one step away from healthcare, and one more step away from improvements in health. Improvements in health stem from appropriate healthcare services being provided to the right person, at the right time, in the right place. Towards improving health, Section 2713 of the ACA sought to improve upon the coverage of appropriate preventive services in health insurance policies:

> *Section 2713. Coverage of Preventive Health Services*
>
> *(a) IN GENERAL. — A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—*
> *(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; …*

Anyone who has had a routine examination or annual flu shot has benefited from this provision of the ACA. By removing financial barriers, the ACA has been associated with increasing use of appropriate preventive services and decreasing racial and ethnic disparities in use of these services (Agirdas & Holding, 2018).

This section of the ACA goes further to consider value-based insurance designs that could extend beyond preventive health services.

> *(c) VALUE-BASED INSURANCE DESIGN. — The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.*

When we began writing about value-based insurance designs two decade ago (Fendrick, Smith, Chernew & Shah, 2001), our focus was on prescription drugs, where cost-sharing continues to be heavily focused on characteristics of the prescription context (e.g. brand vs. generic, acquisition cost) rather than on the health value provided to the patient. Cost-sharing is an important aspect of

the utilization of prescription drugs (Gibson, McLaughlin & Smith, 2010), yet it shouldn't be the *only* consideration. Demonstrations of the use of value-based insurance designs focused on prescription drug use often find similar total costs for prescription drugs, and lower overall healthcare costs (Ford, et al., 2020), precisely as one would hope.

The National Conference of State Legislators (2021) lists numerous examples of the application of value-based insurance designs in public programs. Private sector applications of value-based insurance design are also numerous; though specific details are not generally available unless there is a press release or a publication of effects.

With sufficient numbers of publications of results of public sector and private sector experiments, perhaps guidelines will be promulgated to permit group health plans and health insurance issuers' offering group or individual health insurance coverage to utilize value-based insurance designs.

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