The Affordable Care Act Promises Historic Changes - and Many Challenges

The two main features of the Affordable Care Act - online exchanges and expanded Medicaid - are about to go into effect with wide disparities by state.

By Jon Schuppe | Wednesday, Sep 18, 2013 | Updated 3:26 PM CDT

Getty Images

The Affordable Care Act is a federal law, but its implementation will vary from state to state.

A historic shift in the way Americans pay for their health care is about to begin, but many who stand to gain still don't know what it is, or how it can help them.

In short, the monumental endeavor aims to make it easier for millions of uninsured people get coverage, and expand options for those who already have it.

Known formally as the Affordable Care Act, the measure became law in March 2010, and the major provisions are only now going into effect. Still, after all this time, the project remains politically divisive, with lawmakers in many states resisting its implementation on grounds that the federal government shouldn't be meddling in the way Americans get health coverage.

The U.S. Supreme Court cleared the way for the law's implementation last year, when it sided with the government against opponents who argued it was unconstitutional. But the court said the law went too far in trying to force states to expand Medicaid to more poor Americans. Now

states — which traditionally manage their own insurance markets — have taken sides, with about half embracing the expansion, and the rest declining.

The measure's signature feature, the creation of online "exchanges" where consumers can shop for a new array of insurance policies, is also subject to various degrees of cooperation from state authorities. Those who fully embrace the law are building their own exchanges and spreading the word, while those who oppose are taking a deliberately passive role, leaving most of the work to the federal government. Some have taken more strident measures, including Missouri, which banned local officials from assisting the rollout.

In the 27 states that are not building their own exchanges, the federal government will be running them. That's a massive undertaking, involving unfamiliar work typically performed by state regulators. But the federal government also has the benefit of being able to duplicate well-designed exchanges in multiple markets. Whether the federal exchanges work better than the local ones remains to be seen.

Overhauling the healthcare industry would be complex enough without the state variations. So, with an Oct. 1 goal to get the exchanges running — and a Jan. 1, 2014 deadline for people to obtain insurance — the Obama administration, along with allied local officials, are scrambling to make sure the system works, and that people take part in it.

Few expect a smooth ride.

"We're implementing something of enormous magnitude," said Leslie Beitsch, a health policy analyst at Florida State University who has served as deputy secretary for the Florida Department of Health and as Oklahoma's health commissioner. "Healthcare is an enormous contributor to our economic fabric. And to implement (the reforms) in such a short period of time, the thought that it should go flawlessly is a bit unrealistic."

Long road

The Affordable Care Act is the culmination of many decades of attempts to reform the country's health care system and control its soaring costs, which are higher, per-person, than any industrialized country, although the quality of care isn't necessarily better.

About 48 million people in America do not have health insurance; the new law would to close that gap by about 30 million by 2016. Most of those 30 million fall into three groups: those whose employers don't offer insurance, those who currently buy insurance on their own, and those who are too poor to afford it and are left out of current Medicaid requirements.

Providing coverage to those people is expected to cost about $1 trillion over the next decade; that tab is supposed to be paid through taxes and cuts to other programs.

Those excluded from the new law include people living in the United States illegally, members of Indian tribes, and prisoners.

In addition to giving people access to better health care, there are other anticipated long-term economic benefits, including the creation of more health-care industry jobs and the reduction of so-called "job lock," in which people decline to search for better employment in fear of losing their existing coverage.

But there are still many unknowns, including what exactly the new plans' premiums will be. The market is expected to be highly competitive, but with big price differences among states, towns and age groups.

Many people, including those who don't have insurance and will now have to buy it, are worried about the financial impact. Some analysts are warning of a shortage of doctors and more people seeking care.

Seeking simplicity

Looking at this undertaking from a broad perspective — the political fights, the regulatory changes, the dizzying array of categories and choices — can make the new system seem impossibly complicated. But it doesn't have to be.

Ideally, the best state exchanges will lead customers through simple interfaces that lay out customers' options according to a few basic pieces of information: their age, where they live, and the size of their families (the law prohibits insurers from denying or charging more for coverage of people who are ill). Each coverage option will include the same basic set of benefits. They'll mainly differ according to cost, and will be categorized in that way (for example: bronze, silver, gold, and platinum).

Those with higher premiums will ask lower deductibles and co-pays at the time of treatment, while those with lower premiums will require higher deductibles and co-pays. The upper-tier plans may seem the best option for families with children or with chronic health problems, while the lower tier options may be attractive to young, healthy people who don't expect to see the doctor every often.

Low-income Americans who can't afford care on the private market will generally have two potential choices, depending on their circumstances. Those whose earnings fall under 138 percent of the poverty level will be directed to the newly expanded Medicaid programs (if their states choose to take part). Those who come in above that line will be directed to the online exchanges, where the lowest-income enrollees, up to four times the poverty rate, will be eligible for tax credits and subsidies provided they don't have access to affordable employee coverage.

Most people must have health insurance by Jan. 1, 2014. Those who don't face penalties. The fines start at $95 per person or 1 percent of their income, whichever is greater. The penalties rise in 2016.

The law requires that companies with 50 or more workers offer insurance to their full-time employees by 2015. Smaller businesses don't have to participate, but the smallest may receive tax credits if they do. They will have access to a special insurance pool.

A Final Push

Creating the exchanges, and making them simple to use, requires an incredible amount of work. Some states are farther along in the process than others. And some still haven't decided whether to take part in the Medicaid expansion. That has left a considerable amount of anxiety, particularly within the Obama administration, which hopes to enroll 7 million people in the program's first year. Big mishaps, or low enrollment, could become fodder for a political backlash, and make it more difficult to tweak the law to make improvements.

"Some states have been aggressive in doing this, and are well on their way to having good exchanges," said Ira Wilson, who runs the Department of Health Services, Policy and Practice at Brown University. "Other states not only are not cooperating but are not publicizing, so the exchanges are going to be this federal thing that the state tolerates but doesn't comply with. Think about how weird that is."

Much of the anxiety has been focused on Texas, Florida and California, which together are home to about a third of the country's uninsured. Success depends on high participation rates there. But lawmakers in two of the states, Texas and Florida, have resisted the new system. Federal officials, government contractors and a non-profit advocacy group are spending considerable resources to make sure people know what will be available to them.

California, on the other hand, has embraced the Affordable Care Act, pouring money into the creation of its exchange.

Medicaid Division

Among many healthcare analysts, the most frustrating aspect has been the refusal of many states to offer expanded Medicaid, the initial costs of which would be paid for by the federal government.

Many lawmakers oppose the new law not only on political or philosophical grounds, but also for economic reasons; they fear that when the 100-percent federal subsidy declines to 90 percent, their states won't be able to cover their portion.

But that resistance could essentially deny coverage to millions of people.

"If you are a low-income person who is not Medicaid eligible and your state doesn't expand Medicaid, you could be completely left in the dust," said Christine Eibner, a senior economist at the RAND Corporation.

Until now, Medicaid has traditionally been reserved for poor children, pregnant women, certain parents and the elderly. The expansion will greatly widen eligibility, allowing an expected 10 million more people to enroll.

Although the exchanges will become available Oct. 1, consumers don't need to run to their computers that morning to sign up. In fact, a large-scale charge on the state systems may make them more vulnerable to problems. Officials warn that minor glitches should be expected. The real deadline is to have made a choice by Jan. 1, when coverage kicks in.

"I think (enrollment) is going to be gradual," said Kenneth Thorpe, chair of the Department of Health Care Policy and Management at Emory University. "There's not a big rush."

"It will happen," Wilson added. "It will be a mess in certain states for a while. The first year will be bumpy. But I think it will be very important — important for patients and important for health care providers. For people who buy health care, this is profound."