The Affordable Care Act: What's the latest?

Although the ACA has reduced the US uninsured rate significantly, some setbacks and obstacles to widespread coverage require further action

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When I last wrote about the Affordable Care Act (ACA), in May 2014, I focused on the contraception issue. Since then, the US Supreme Court ruled, in *Burwell v. Hobby Lobby*, that closely held, for-profit companies with religious objections to covering birth control can opt out of the requirement to provide contraceptive coverage to their employees.

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In this article, I explore that decision and what it means for women's health. I also present data on the uninsured rate in the United States, which has dropped significantly since enactment of the ACA, and I discuss one increasingly common barrier to access to care—the use of narrow networks by insurers.

A corporation now can hold a religious belief

The Supreme Court's majority 5-4 ruling recognized, for the first time, that a for-profit corporation can hold a religious belief, but the Court limited this claim to closely held corporations. The Court also decided that the ACA placed a substantial burden on the corporations' religious beliefs and concluded that there are less burdensome ways to accomplish the law's intent, rendering the contraceptive coverage provision in the ACA in violation of the Religious Freedom Restoration Act (RFRA). The Court limited its ruling to the contraceptive coverage requirement, essentially turning the requirement into an option for many employers.

What is a closely held corporation?

In general, according to the Pew Research Center, a closely held corporation is a private company (not publicly traded) with a limited number of shareholders. The Internal Revenue

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Are contraceptives abortifacients?

The religious belief at the center of *Burwell v. Hobby Lobby* was that life begins at conception, which the Green family—the owners of Hobby Lobby—equate to fertilization. Hobby Lobby's attorneys also asserted that four contraceptives approved by the US Food and Drug Administration and included in the ACA mandate may prevent implantation of a fertilized egg, thereby constituting abortion.

Although there is no scientific answer as to when life begins, ACOG and the medical community agree that pregnancy begins at implantation. In its amicus brief to the US Supreme Court, ACOG asserted the medical community's consensus that the four contraceptives prevent pregnancy rather than end it, and are not abortifacients:

- emergency contraceptive pills: levonorgestrel (Plan B) and its generic equivalents and ulipristal acetate (ella)
- the copper IUD (ParaGard)
- levonorgestrel-releasing intrauterine systems (Mirena, Skyla).

The uninsured rate for young adults declined from 28% to 18% after enactment of the ACA

Service (IRS), an important source, defines a closely held corporation as one in which more than half of the stock is owned (directly or indirectly) by five or fewer individuals at any time in the second half of the year.

"S" corporations are also considered closely held. These are corporations with 100 or fewer shareholders, with all members of the same family counted as one shareholder. "S" corporations don't pay income tax; their shareholders pay tax on their personal returns, based on the corporations' profits and losses.

Hobby Lobby is organized as an "S" corporation. According to the IRS, in 2011, there were 4,158,572 "S" corporations, 99.4% of them with 10 or fewer shareholders.[1]

The US Census Bureau estimates that, in 2012, about 2.9 million "S" corporations employed more than 29 million people. Many closely held corporations are quite large.[2] According to the Pew Research Center, family-owned Cargill employs 140,000 people and had $136.7 billion in revenue in fiscal 2013. Hobby Lobby has estimated revenues of $3.3 billion and 23,000 employees.[2]

What's next?

ACOG helped secure coverage of contraceptives in the ACA and is working with the US Congress and our women's health partners to restore this important care. Days after the Supreme Court decision, Senator Patty Murray (D-WA) introduced the Protect Women's Health from Corporate Interference Act, S. 2578, with 46 cosponsors as of this writing. ACOG fully supports this bill, also known as the "Not My Boss' Business Bill," which would reestablish the contraceptive coverage mandate as well as other care required by federal law. This bill still maintains the exemption from contraceptive coverage for houses of worship and the accommodation for religious nonprofits.

In introducing her bill, Senator Murray pointed out that "the contraceptive coverage requirement has already made a tremendous difference in women's lives—24 million more prescriptions for oral contraceptives were filled with no copay in 2013 than in 2012, and women have saved $483 million in out-of-pocket costs for oral contraceptives."[3]

Uninsured rate is declining

The Commonwealth Fund shows that, from July–September 2013 to April–June 2014, the nation's uninsured rate fell from 20% to 15%, resulting in 9.5 million fewer uninsured adults.[4] The biggest drop occurred among young adults, with the uninsured rate falling from 28% to 18%, and in states that adopted the Medicaid expansion, where uninsured rates fell from 28% to 17%.[4]

States that didn't expand their Medicaid program didn't show any noticeable change, with the uninsured rate declining only two points, from 38% to 36%.[4]

Coverage resulted in access to care for the majority of the newly covered. Sixty percent of people with new coverage visited a provider or hospital or paid for a prescription. Sixty-two percent of these individuals said they wouldn't have been able to access this care before getting this coverage. Eighty-one percent of people with new coverage said they were better off now than before.[4]

ACA works better in some states than others

The Kaiser Family Foundation looked at four successful states—Colorado, Connecticut, Kentucky, and Washington state—to see what

How the Hobby Lobby decision affects individual states

Because the Supreme Court's decision concerned interpretation of a federal law—the Religious Freedom Restoration Act (RFRA)—it does not supersede state laws that mandate coverage of contraceptives.

Twenty-eight states have laws or rulings requiring insurers to cover contraceptives, most of them dating from the 1990s and providing some exemption for religious insurers or plans. Only Illinois allows an exemption for secular bodies.

Although these state laws remain in effect, state officials may opt to stop enforcing them with regard to certain companies. For example, after the Hobby Lobby decision, Wisconsin officials announced that they no longer will enforce contraceptive coverage when a company has a religious objection.

For companies that self-fund or self-insure worker health coverage, the state coverage laws don't apply—only federal law does. These companies do not have to adhere to state insurance mandates.

Some states have their own version of the RFRA. See the chart at right for details on a state-by-state basis.

The Supreme Court ruling also has no effect on state laws that guarantee access to emergency contraception in hospital emergency departments and that require pharmacists to dispense contraceptives.

State	Contraceptive equity law?	Employer/ insurer exemption to equity law?	Religious freedom law?
Alabama			✔
Alaska			
Arizona	✔	✔	✔
Arkansas	✔	✔	
California	✔	✔	
Colorado	✔		
Connecticut	✔	✔	✔
Delaware	✔	✔	
Florida			✔
Georgia	✔		
Hawaii	✔	✔	
Idaho			✔
Illinois	✔	✔	✔
Indiana			
Iowa	✔		
Kansas			
Kentucky			✔
Louisiana			✔
Maine	✔	✔	
Maryland	✔	✔	
Massachusetts	✔	✔	
Michigan	✔	✔	
Minnesota			
Mississippi			✔
Missouri	✔	✔	✔
Montana	✔		
Nebraska			
Nevada	✔	✔	
New Hampshire	✔		
New Jersey	✔	✔	
New Mexico	✔	✔	✔
New York	✔	✔	
North Carolina	✔	✔	
North Dakota			
Ohio			
Oklahoma			✔
Oregon	✔	✔	
Pennsylvania			✔
Rhode Island	✔	✔	✔
South Carolina			✔
South Dakota			
Tennessee			✔
Texas			✔
Utah			
Vermont	✔		
Virginia			✔
Washington	✔		
West Virginia	✔	✔	
Wisconsin	✔		
Wyoming			
TOTAL	28	20	18

lessons can be learned. **Important commonalities include the fact that the states run their own marketplace, adopted the Medicaid expansion, and conducted extensive outreach and public education, including engaging providers in patient outreach and enrollment.**[5]

Other tools of success were developing good marketing and branding, providing consumer-friendly assistance, and attention to systems and operations.[5]

Narrow networks limit access to care

Huge concerns abound regarding implementation and real-life experiences related to the

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ACA. A number of them—high deductibles, low payment rates, limited access to physicians, long drive and wait times—can be related to "narrow networks." Insurers exclude certain providers and offer all providers lower payment rates (which leads some physicians to drop out of the plan); they also create tiers (charging consumers lower copays and deductibles for using inner-tier preferred providers and high out-of-pocket costs for using other providers, even though they may be in the network).

Narrow networks work for insurers as an effective tool for lowering provider payment rates to keep premiums low and gain market share. The narrower the network, the lower are physician payments and premiums.

The ACA promises expanded access to high-quality, affordable health care for millions of Americans—a promise being compromised in many areas of the country through narrow networks. In these instances, insurers offering new plans in a health-care marketplace limit patient access to the numbers, types, and locations of physicians and hospitals covered under certain plans. Insurers typically offer patients low premiums, offer selected providers a high volume of patients at low payment levels, and exclude other providers whom the insurer deems to be high-cost.

The narrower the insurance network, the lower physician payments and premiums are

Narrow networks aren't new

As with so many elements of the ACA, narrow networks aren't a new phenomenon. Many of us remember the public relations price that HMOs paid in the 1980s and 1990s for exceedingly limiting patients' access to care while charging low premiums. The consumer outcry led the National Association of Insurance Commissioners to urge states to require managed-care plans to maintain adequate networks, the approach adopted by the federal government in the ACA.[6]

The pendulum swung in the next decade to broader networks in which consumers had much greater access, but premiums increased by an average of 11% per year.[6] Employers then pushed insurers to reduce premium costs, leading back to narrow networks in the years just before the ACA. Narrow network plans accounted for 23% of all employer-sponsored plans in 2012, up from 15% in 2007.[6]

Increasing consolidation contributes to narrow networks

The trend toward narrower networks is also linked to increasing consolidation in health care. As health systems grow and individual or small group practices disappear, insurers rely on being able to credibly threaten to exclude systems and big groups from their networks as leverage in payment negotiations. By restricting the choice of providers in a plan, the insurer can promise more customers for the doctors and hospitals that are included, and negotiate lower payments to those providers.

The downside for physicians is clear:

- low payment rates
- exclusion from networks and coverage
- inability to refer patients to providers the physician determines to be best for that patient's needs.

The downside for patients:

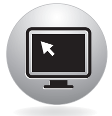
- If they have to go out of network to get needed care, they may end up paying high out-of-pocket costs
- If they delay or forego care, their health may suffer significantly.

The insurance industry's position is that patients have choices. Plans with access to more hospitals and specialists are available but usually at a higher price.

Narrow networks are one way to achieve low premiums

In the months leading up to ACA enactment, insurers got to work developing plans designed to be sold on the exchanges that would attract consumers through low-cost premiums and still maximize profits, especially now that insurers, under the ACA, are barred from excluding sick enrollees or increasing premiums for women, in addition to other important protections.

In previous articles, we've explored these landmark protections. Insurers in the individual market used to be able to keep premiums



relatively low, and profits up, through use of preexisting coverage exclusions, benefit exclusions including noncoverage for maternity care or prescription drugs, and high cost sharing. Not anymore.

Since enactment of the ACA, narrow networks seem to be the preferred, and most effective, payment negotiation tool of many insurers offering plans through the exchanges, reflecting the trend we're already seeing in the private health insurance marketplace.

NPR spotlights the difficulty of finding a specialist

The consumer and provider problems of narrow networks have been gaining attention in the media. In July, the National Public Radio (NPR) Web site carried an article entitled, "Patients with low-cost insurance struggle to find specialists," with a key subtitle: "So you found an exchange plan. But can you find a provider?"[7]

In the NPR article, author Carrie Feibel reported on the situation in a majority-immigrant area of southwest Houston.

There, many patients at the local clinic have health insurance coverage for the first time, an important step toward healthier lives for themselves and their families. But many people in need of a specialist are learning that their insurance card doesn't guarantee them access to a needed surgeon or hospital. They've purchased a narrow-network insurance plan, with a low premium but few specialists who accept that insurance.[7]

The two largest hospital chains in Houston—Houston Methodist and Memorial Hermann—as well as Houston's MD Anderson Cancer Center, don't participate in the Blue Cross Blue Shield HMO Silver plan, a plan popular with low-income consumers because of its low premium.[7]

Will the government take action?

The ACA actually guards against overly narrow networks and established the first national standard for network adequacy—a standard that needs fuller development, for sure. Plans sold on the exchanges are required to establish networks that include, among other providers, essential community providers, who typically care for mostly low-income and medically underserved populations. Networks also must include sufficient numbers and types of providers, including "providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[8]

Insurers also must provide people who are considering purchasing their products with an accurate directory—both online and a hard copy—identifying providers not accepting new patients in the network. And plans are prohibited from charging out-of-network cost-sharing for emergency services.

Much of the oversight and many of the details—how much is adequate? what is unreasonable?—are left to the states, many of which have years of experience grappling with the downsides and delicate balance of networks.

The Urban Institute points out that Vermont and Delaware set standards for maximum geographic distance and drive times for primary care services. In California, plans must make it easy for consumers to reach urban providers on public transportation.[6]

Professional societies are taking note

Today, the misuse of narrow networks by exchange plans also has gotten the attention of the American Medical Association, ACOG, and many other national medical specialty societies, in addition to the states and federal government.

The trick, many health-care policy experts agree, is to find the right balance. How broad can the network be before premiums soar? Most agree that consumers must be able to choose between plans with confidence, without any cost or access surprises, meaning much better transparency. And many agree that provider quality, in addition to cost, has to find its way into the equation.

This year, the Center for Consumer Information and Insurance Oversight, a part of the federal Department of Health and Human Services created by the ACA to investigate these kinds of issues, is investigating access

The ACA requires insurance networks to "assure that all services will be accessible without unreasonable delay"

to hospital systems, mental health services, oncology, and primary care providers and is developing time, distance, and other standards that insurers will have to adhere to.

Employer groups oppose strong standards or limits on narrow networks. Recently, representatives of the US Chamber of Commerce, the National Retail Federation, and others warned Congress to stay out of this fight. They understand that more generous networks mean higher premiums. These employer representative groups prefer to strengthen consumer protections like directories and keep low the cost of health insurance that they provide for their employees.

Employer groups oppose strong standards or limits on narrow networks because more generous networks mean higher premiums

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