December 2018 | Fact Sheet

Potential Impact of *Texas v. U.S.* Decision on Key Provisions of the Affordable Care Act

Background

On December 14, 2018, a federal trial court judge ruled that the entire Affordable Care Act (ACA) is unconstitutional. While the trial court's ruling is likely not the last word on the ACA's constitutionality, this brief considers the complex and far-reaching impact were the entire law ultimately held to be invalid.

The case – brought by a number of Republican state attorneys general (AGs) and other plaintiffs – centers on the argument that the law's individual mandate is unconstitutional after Congress zeroed out the penalty associated with it in the tax bill in late 2017. The plaintiffs argue that the rest of the ACA is not severable from the mandate and should therefore be invalidated. The Trump administration agrees that the mandate should be judged unconstitutional, but argues that only the ACA's pre-existing condition protections are inseparable from the mandate and should be overturned, while the rest of the law should stand. A number of Democratic state AGs are defending the ACA as interveners in the case, arguing in part that Congress intended to keep the ACA in place when it set the individual mandate penalty to zero while leaving the rest of the law intact. The Trump administration has indicated that it intends to continue enforcing the ACA pending an expected appeal of the decision.

The number of non-elderly Americans who are uninsured decreased by 19.1 million from 2010 to 2017 as the ACA went into effect. While the ACA's changes to the individual insurance market – including protections for people with pre-existing conditions, creation of insurance marketplaces, and premium subsidies for low and modest income people – have been the focus of much policy debate and media coverage, the law made other sweeping changes throughout the health care system that have an impact on nearly all Americans. These include: the expansion of Medicaid eligibility for low-income adults; required coverage of preventive services with no cost sharing in private insurance, Medicare, and for those enrolled in the Medicaid expansion; phase-out of the "doughnut hole" gap in Medicare drug coverage; reductions in the growth of Medicare payments to health providers and insurers; new national initiatives to promote public health, the quality of care, and delivery system reforms; and a variety of tax increases to finance these changes. These provisions could all be overturned if the judge's decision is upheld.

More than eight years after enactment, ACA changes to the nation's health system have become embedded and affect nearly everyone in some way. A court decision that invalidated the ACA, therefore, would also affect nearly everyone in at least some way. It would be a complex undertaking to try to

disentangle it at this point. The following table summarizes the major provisions of the ACA, illustrating the breadth of its changes to the health care system and public attitudes towards those changes.

Table 1. Summary of Key Coverage-Related Provisions of the ACA, With Estimates of Their Impact and the Public's Views		
Key Provision	**People Affected/Dollars Involved**	**Public Opinion**
Expanded Eligibility for Health Coverage		
Medicaid Eligibility Expansion - Medicaid eligibility is expanded to include adults with income up to 138% FPL; however, the Supreme Court ruling in 2012 essentially made Medicaid expansion optional for states. - The federal government paid 100% of the cost of the expansion initially; this share phases down to 93% in 2019 and 90% in 2020 and beyond	- In FFY 2017, there were more than 17 million Medicaid expansion enrollees in the 32 states and DC that had adopted the expansion. Of those enrollees, 12.7 million were newly eligible due to the ACA's Medicaid expansion	- 77% of the public have a favorable view of provision giving states option to expand Medicaid programs (91% of Dems, 77% of Inds, 55% of Reps) (Nov 2018) - 59% of those living in non-expansion states would like to see their state expand Medicaid (Nov 2018) - Most of those living in non-expansion states say that if their state government chooses not to expand Medicaid, voters themselves should be able to decide. (Nov 2018)
Subsidies for Non-Group Health Insurance - Eligible individuals who buy coverage through the Marketplace receive subsidies based on income: premium tax credits for those with income 100-400% FPL; cost-sharing subsidies for those with income 100-250% FPL - States can also elect to run a subsidized Basic Health Plan for people with income between 133%-200% FPL	- As of June 2018, 8.9 million marketplace enrollees received premium tax credits and 5.4 million received cost-sharing reductions - In 2018, there were about 0.8 million people enrolled in the Basic Health Plans in Minnesota (92,421) and New York (738,851)	- 81% of the public (92% of Dems, 82% of Inds, 63% of Reps) have a favorable view of providing financial help to low- and moderate-income Americans who buy their own insurance (Nov 2018)
Dependent Coverage to 26 - All non-grandfathered private group and non-group health plans must extend dependent coverage to adult children up to the age of 26	- About 2.3 million young adults gained coverage as a result of this provision	- 82% of the public (90% of Dems, 82% of Inds, 66% of Reps) have a favorable view of allowing young adults to stay on parents' insurance plans until age 26 (Nov 2018)
Health Insurance Marketplace - Establish new marketplaces where qualified health plans are offered to individuals.	- 10.3 million individuals had effectuated coverage through the Marketplace as of the first half of 2018	- 82% of the public (91% of Dems, 78% of Inds, 71% of Reps) have a favorable view of creating health insurance exchanges where people and small businesses can shop for insurance (Nov 2018)

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- Marketplaces certify that qualified health plans meet all ACA requirements, provide subsidies to eligible individuals, operate a website to facilitate application and comparison of health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators		- 53% think the marketplaces are collapsing (March 2018) - 51% say stabilizing the marketplaces should be a top priority for President Trump and Congress (January 2018)
Federal Minimum Standards for Private Health Insurance		
Protections for Pre-existing Conditions - All non-grandfathered plans are prohibited from discriminating against individuals based on their health status. - Insurers in the non-group, small group, and large group market must guarantee issue coverage - Large group, small group, and non-group health plans are prohibited from applying pre-existing condition exclusions - Insurers in the non-group and small group market may not vary premiums based on health status or gender or any other factor except: - Premiums can vary by age (up to 3:1), geography, and family size - Rescission of coverage is prohibited in the non-group, small group, and large group market	- 52 million people (27% of the nonelderly population) have a pre-existing condition that would have been deniable in the pre-ACA individual market.	- Majorities say it is "very important" to them that the ACA provisions prohibiting insurance companies from denying coverage (65%) or charging sick people more (62%) remain law (Nov 2018) - 70% overall (87% of Dems, 67% of Inds, 51% of Reps) would want their state to establish protections for people with pre-existing health conditions if the ACA's protections are ruled unconstitutional. (Nov 2018) - 58% of Americans say someone in their household has a pre-existing health condition. (Nov 2018) - 41% are "very worried" that they or a family member will lose coverage if the Supreme Court overturns ACA's pre-existing condition protections (August 2018) - 52% are "very worried" that they or a family member will have to pay more for coverage if the Supreme Court overturns ACA's pre-existing condition protections (Sept 2018)
Preventive Services - All non-grandfathered group and non-group plans must cover	- 84% of covered workers with employer-sponsored insurance (approximately 131 million people)	- 79% of the public (88% of Dems, 78% of Inds, 68% of Reps) have a favorable view of eliminating out-

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preventive health services without cost sharing. - Covered services include breast, colon, and cervical cancer screening, pregnancy-related services including breastfeeding equipment rental, contraception, well-child visits, adult and pediatric immunizations, and routine HIV screening. In addition, it was recently recommended that pre-exposure prophylaxis (PREP) to prevent HIV infection be included as well and if finalized, would be offered at no-cost	were enrolled plans that must provide free preventive services as of 2017. - 13.1 million people were enrolled in individual market plans required to provide free preventive services, as of 2017 - 17 million enrollees in Medicaid expansion states received coverage for preventive services in 2017 - Prior to the ACA, 1 in 5 women reported that they postponed or went without preventive care due to cost. - The share of women of reproductive age with large employer coverage who had out-of-pocket spending on oral contraceptive pills fell from 22.7% in 2012 to 2.7% in 2016.	of-pocket costs for many preventive services (Nov 2018)
Essential Health Benefits - All ACA compliant health plans in the individual and small group market must cover 10 categories of essential health benefits (EHB), including hospitalization, outpatient medical care, maternity care, mental health and substance abuse treatment, prescription drugs, habilitative and rehabilitative services, and pediatric dental and vision services	- In 2013, before the ACA EHB requirements took effect, 75% of non-group health plans did not cover maternity care, 45% did not cover substance use disorder treatment, and 38% did not cover mental health services	- 66% of the public (81% of Dems, 65% of Inds, 52% of Reps) say they want the federal government to continue to require health insurance companies to cover a certain set of benefits (June 2017)
Annual and Lifetime Limits - All group and non-group plans (including non-grandfathered) are prohibited from placing lifetime or annual limits on the dollar value of coverage for essential health benefits	- Prior to the ACA, in 2009, 59% of covered workers' employer-sponsored health plans had a lifetime limit - 156 million people (57% of the U.S. non-elderly population) had employer coverage as of 2017.	
Cap on Out-of-Pocket Cost Sharing - All non-grandfathered private health plans must limit cost sharing for essential health benefits covered in network	- Prior to the ACA, in 2009, 19% of covered workers had no limit on out-of-pocket expenses. Among those with out-of-pocket maximums, not all expenses counted toward the limit. For example, in 2009, among workers in PPOs with an out-of-pocket maximum, 85% were in plans that did not count prescription drug spending	

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- The annual maximum for 2019 is $7,900 for an individual; $15,800 for family coverage	when determining if an enrollee had reached the out-of-pocket limit.	
Minimum Medical Loss Ratios **-** Require all non-grandfathered private plans to pay a minimum share of premium dollars on clinical services and quality - Insurers must provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.	In total, $4 billion in medical loss ratio rebates have been issued across the individual, small group, and large group markets, from 2012 to 2018 (based on insurer financial results from the 2011-2017 plan years).	- 62% of the public (68% of Dems, 64% of Inds, 54% of Reps) say they favor requiring insurance companies that spend too little money on health care services and too much on administrative costs and profits to give their customers a rebate (March 2014)
Consumer Information and Transparency - All non-grandfathered health plans must provide a brief, standardized summary of coverage written in plain language - All non-grandfathered health plans must periodically report transparency data on their operations (e.g., number of claims submitted and denied)		- 79% of the public have a favorable view, including 91% of Dems, 78% of Inds, 68% of Reps (August 2012)
Other Provisions Affecting Employers/Group Health Plans		
Large Employer Mandate - Requires employers with at least 50 full time workers to provide health benefits or pay a tax penalty		- Favored by a majority across parties: 69% overall have a favorable view, including 88% of Dems, 61% of Inds, 56% of Reps (November 2018)
Waiting Periods - Employers that impose waiting periods on eligibility for health benefits (e.g., for new hires) must limit such periods to no more than 90 days	- Prior to the ACA, in 2009, 29% of covered workers faced a waiting period of 3 months or more	
Consumer Assistance		
State Consumer Assistance Programs	-CAPs were established in most states in 2010, though no appropriations for CAPs have since	

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- Authorize federal grants for state Consumer Assistance Programs (CAPs) to advocate for people with private coverage. - Notice of claims denials by non-grandfathered private plans must include information about state CAPs that will help consumers file appeals	been enacted. Today 36 CAPs are in operation - A report on the first year of CAP operations found the programs helped 22,814 individuals successfully challenge their health plan decisions and obtained more than $18 million on behalf of consumers.	
Other Medicaid Provisions		
Simplification of Enrollment Processes - States are required to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges.	- Prior to the ACA in 2013, 27 states had an asset test and 6 required face-to-face interviews for parents; only 36 states had an online Medicaid application and 17 states allowed individuals to apply by phone. By 2018, nearly every state had an online and telephone Medicaid application, and all states had eliminated asset tests and face-to-face interviews.	
Long-term Care Services and Supports - Expands financial eligibility for 1915 (i) home and community-based services (HCBS), creating a new eligibility pathway to allow people not otherwise eligible to access full Medicaid benefits, allows states to target services to specific populations, and expands the services covered. - Creates a new Medicaid state plan option to cover attendant care services and supports with 6% enhanced FMAP.	- 18 states elected the option to expand eligibility for 1915(i) HCBS services as of 2016. Almost 62,000 individuals received services and over $237 million was spent on these services. - As of 2016, 8 states elected the option to cover attendant care services. Over 353,000 individuals received services and $8.2 billion was spent on these services.	
Behavioral Health Parity **-** Mental health and substance use disorder services must be included in Medicaid Alternative Benefit Packages (ABPs) provided to Medicaid expansion adults and other adults, and the services must be covered at parity with other medical benefits.	- 17 million Medicaid expansion enrollees receive services through an ABP.	
Medicaid Eligibility for Former Foster Care Youth up to Age 26 – Requires states to provide Medicaid to young adults ages 21		

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through 26 who were formerly in foster care.		
Medicaid Drug Rebate Percentage Increase Medicaid drug rebate percentage for most brand name drugs to 23.1% and increase Medicaid rebate for non-innovator multiple source drugs to 13%. Extend drug rebate program to Medicaid MCOs	- CBO estimated federal savings of $38 billion over 10 years from the Medicaid prescription drug provisions in the ACA, including increases in the drug rebate percentage	
Medicare Provisions		
Part D Coverage Gap[1] Gradually close the Medicare Part D coverage gap ("doughnut hole"): - Phase down the beneficiary coinsurance rate for brand and generic drugs In the Medicare Part D coverage gap from 100% to 25% by 2020 - Require drug manufacturers to provide a 50% discount on the price of brand-name and biologic drugs in the coverage gap - Reduce the growth rate in the catastrophic coverage threshold amount between 2014 and 2019 to provide additional protection to enrollees with high drug costs	- 43 million people were enrolled in Medicare Part D in 2018 - In 2016, more than 5 million Part D enrollees without low-income subsidies (LIS) had spending in the coverage gap and received manufacturer discounts averaging $1,090 on brand-name drugs. Reinstating the coverage gap would increase costs incurred by Part D enrollees who have relatively high drug spending.	- 81% of the public (79% of seniors) has a favorable view that "the law gradually closes the Medicare prescription drug 'doughnut hole' or 'coverage gap' so people on Medicare will no longer be required to pay the full cost of their medications when they reach the gap" (Nov 2018)
Preventive Services - Eliminate cost sharing for Medicare covered preventive services. Authorize coverage of annual comprehensive risk assessment for Medicare beneficiaries.	- 60 million people have access to free preventive services; of these, Medicaid pays Medicare cost sharing for 10 million full dual eligibles.	
Cost Sharing in Medicare Advantage (MA) - Prohibit MA plans from imposing higher cost-sharing requirements than traditional Medicare for	- 20 million people enrolled in Medicare Advantage plans in 2018	

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chemotherapy, renal dialysis, skilled nursing care, and other services deemed appropriate by the Secretary of HHS. This prohibition was extended to most Medicare-covered services.		
Restructure Medicare Advantage Payments - Reduce federal payments to Medicare Advantage plans to bring payments closer to the average costs of Medicare beneficiaries. - Provide quality-based bonus payments to Medicare Advantage plans - Require Medicare Advantage plans to maintain a medical loss ratio of at least 85 percent; the administration extended this requirement to all Part D plans.	- CBO estimated repeal of the ACA Medicare Advantage payment changes would increase Medicare spending by about $350 billion over 10 years (2016-2025). - Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund.	
Other Provider Payments - Reduce the rate at which Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers are updated annually. - Reduce Medicare Disproportionate Share Hospital (DSH) payments that help to compensate hospitals for providing care to low-income and uninsured patients. - Allow providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds to share in cost savings they achieve for the Medicare Program.	- CBO estimated repeal of the ACA provider payment reductions would increase Medicare spending by another approximately $350 billion over 10 years (2016-2025). - Eliminating the Medicare Shared Savings Program ACOs could affect around 10.5 million Medicare beneficiaries who were attributed to a MSSP ACO, as of 2018 - Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund. .	
Medicare Income-related Premiums[2]	- As originally enacted in the ACA, CBO estimated $35.7 billion in savings from these provisions over 10 years	

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Freeze threshold for income-related Medicare Part B premiums for 2011 through 2019 Establish new income-related premium for Part D, with the same thresholds as the Part B income-related premium.		

Additional Provisions

Beyond coverage-related provisions, the ACA made numerous other changes in federal law to safeguard individual civil rights, authorize new programs and agency activities, and finance new federal costs under the law. The Court ruling finding the ACA unconstitutional could also result in an end to these provisions. They include:

Nondiscrimination

The ACA prohibits discrimination against individuals on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, under Section 1557, which builds on long-standing and familiar Federal civil rights laws. Regulations implementing Section 1557 issued by the Obama Administration further defined these protections to include gender identity and pregnancy status. However, a federal court issued a nationwide injunction prohibiting enforcement of the gender identity and pregnancy protections and new regulations are pending. Separate ACA regulations governing marketplaces and qualified health plans, essential health benefits, and the individual and group market also provide nondiscrimination protections, including based on sexual orientation and gender identity, and are not directly affected by the 1557 ruling.

Enforcement by the Office of Civil Rights at the US Department of HHS is ongoing. In addition, individuals can file a civil lawsuit to challenge a nondiscrimination violation under Section 1557.

FDA Approval of Biosimilars

The ACA authorized the U.S. Food and Drug Administration (FDA) to approve generic version of biologics (biosimilars) and grant biologics manufacturers 12 years of exclusive use before generics can be developed. As of December 2018, the FDA has approved 16 biosimilar products used in the treatment of cancer, rheumatoid arthritis, and other health conditions.

Innovation Center

The law also established an Innovation Center within the Center for Medicare and Medicaid Services (CMS) to test, evaluate and expand different payment structures and methods to save costs while maintaining or improving quality of care. Payment and delivery system models supported by the Innovation Center focus on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), for example, include care delivery for children and pregnant women affected by the opioid crisis, and models to reduce prescription drug costs.

Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund with a permanent annual appropriation to support activities related to prevention, wellness and public health activities. The law appropriated $7 billion annually through 2015 and $2 billion for each fiscal year thereafter, although Congress has since voted several times to redirect a portion of funds from the Prevention and Public Health Fund for other purposes. Fund resources support federal, state, and local programs to fight obesity, curb tobacco use, prevent the onset of chronic conditions such as diabetes and heart disease, promote immunization, detect and respond to infectious diseases and other public health threats, and other initiatives.

Nonprofit Hospitals

The ACA set new requirements for non-profit hospitals in order to retain their tax exempt status. These include a requirement to conduct a community needs assessment every 3 years and adopt a strategy to meet identified needs. Hospitals also must adopt and widely publicize financial assistance policies on the availability of free or discounted care and how to apply. In addition, hospitals must limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and must make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions.

Breastfeeding breaks & separate rooms

Employers with 50 or more employees must now provide adequate break time for breastfeeding women and a private space that is not a bathroom for nursing and pumping.

Menu labeling

Restaurants and retail food establishments with 20 or more locations and owners of 20 or more vending machines must include nutrition information, including calories, for their standard menu items.

Revenue Provisions

Many of the revenue provisions enacted under the ACA remain in effect but presumably would end if the law were found unconstitutional. For example, the ACA included a tax on pharmaceutical manufacturers and importers (generating annual fees of $2.8 billion in 2019 and thereafter) and a tax on health insurers (generating annual fees of $14.3 billion in 2018, indexed annually by the rate of premium growth, but subject to a moratorium in 2019). The law also imposed a new medical device excise tax of 2.3%, which Congress has voted several times to delay. Financing provisions also included a 10% tax on indoor tanning services, and limits on the deductibility of compensation of insurance company executives (limited to $500,000 per individual per year). Under the ACA, the Medicare payroll tax was increased for high income earners (over $200,000 by individuals, $250,000 for married couples filing jointly), and a new 3.8% tax on net investment income applied for higher income taxpayers. Finally, the ACA imposed the so-called Cadillac tax on high-value employer-sponsored health plans, which Congress has also voted to delay, most recently, until 2022.

End Notes

[1] Some of the coverage gap provisions were subsequently modified by the Bipartisan Budget Act of 2018. The BBA closes the Part D coverage gap in 2019 instead of 2020 by accelerating a reduction in beneficiary coinsurance from 30 percent to 25 percent in 2019; also increases the discount provided by manufacturers of brand-name drugs in the coverage gap from 50 percent to 70 percent, beginning in 2019. In 2019 and later years, Part D plans will cover the remaining 5 percent of costs in the coverage gap, which is a reduction in their share of costs (down from 25 percent).

[2] Some of the Medicare income-related premium provisions have been modified by subsequent laws. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made changes to Medicare's income-related premiums by requiring beneficiaries with incomes above $133,500 ($267,000 for married couples) to pay a larger share of Part B and Part D program costs than under the original MMA and ACA provisions. Under MACRA, beginning in 2018, beneficiaries with incomes above $133,500 and up to $160,000 ($267,000-$320,000 for married couples) were required to pay 65 percent of Part B and Part D program costs, up from 50 percent prior to 2018, while beneficiaries with incomes above $160,000 and up to $214,000 ($320,000-$428,000 for married couples) were required to pay 80 percent of Part B and Part D program costs, up from 65 percent. The most recent change to Medicare's income-related premiums was incorporated in the Bipartisan Budget Act of 2018 (BBA). This change will affect beneficiaries with incomes above $500,000 ($750,000 for married couples) by requiring them to pay 85 percent of program costs beginning in 2019, up from 80 percent prior to 2019.