EFFECTS OF THE AFFORDABLE CARE ACT

and the Importance of Stability

CENTER FORWARD

EXECUTIVE SUMMARY
Key Findings

The Patient Protection and Affordable Care Act (ACA), the comprehensive health care law passed by Congress and signed into law by President Barack Obama in 2010, transformed the way the U.S. health care system provides health insurance coverage and controls health care costs, and modified how health care is delivered.

Prior to the ACA, many Americans faced higher health care costs and less access to care, resulting in nearly 44 million Americans lacking health care coverage. Further, in the individual market, more than 60 percent of patients did not have access to maternity coverage, 30 percent did not have coverage for substance use treatment, nearly 20 percent did not have coverage for mental health care services, and almost 10 percent did not have coverage for prescription medications.

After the ACA was signed into law and key provisions were implemented, nearly 20 million Americans gained health insurance coverage through the law's expansion of public and private insurance. Groups that typically had high uninsured rates rapidly gained coverage, including young adults, people of color, and low-income people. One of the most important coverage provisions of the ACA is the guarantee that health insurers cannot deny coverage or charge higher premium rates based on an individual's pre-existing conditions. Nearly 54 million Americans, or 27 percent of adults under 65, have a pre-existing condition that would have made them uninsurable prior to the enactment of the ACA. Further, nearly 2.3 million young adults gained coverage through the ACA's requirement that they remain on their parent's insurance plan until age 26.

Additionally, the ACA made a number of significant changes to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) that have had longstanding positive effects. The law expanded Medicaid coverage for adults with incomes up to 138 percent of the federal poverty level (FPL), and expanded Medicaid eligibility for all children up to age 19 to 138 percent FPL and established tax credits and options for coverage under the new health insurance marketplaces.The law also began shifting the Medicare program from a fee-for-service based payment model to focus on increasing provider accountability over the quality and cost of health care services. These policy changes in the ACA resulted in expanded access to affordable care, utilization of services, and financial security for low-income and other vulnerable populations.

By transforming the ways in which Americans receive health insurance, the ACA reduced exposure to high medical expenses and increased access to coverage, improving both short and long-term health outcomes and financial security for Americans, and thereby reducing socioeconomic disparities in the United States.

While the United States continues to grapple with the COVID-19 pandemic, and nearly 31 million Americans experience job loss, the ACA can provide a safety net for individuals losing their employer sponsored health insurance (ESI). Americans are able to enroll in health insurance coverage through the ACA marketplace exchanges and qualify for financial assistance with premiums and cost-sharing responsibilities. They are also able to enroll through the ACA's expansion of Medicaid eligibility in states that have expanded the program. As of June 2020, roughly 487,000 people signed up for an ACA insurance plan after losing their ESI since the last

open enrollment period that ended in December 2019, which is a 46 percent increase in sign-ups compared to the same period last year.

Further, all forms of public and private insurance, including self-funded plans, must now cover FDA-approved COVID-19 tests and costs associated with diagnostic testing with no cost-sharing, as long as the test is deemed medically appropriate by an attending health care provider as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. When a vaccine for COVID-19 is eventually approved, it will most likely be covered for nearly all insured people without cost-sharing, under the ACA requirement that federally-recommended preventative care be covered without cost-sharing for anyone enrolled in private insurance, Medicare, or in the Medicaid expansion.

Meanwhile, support of the ACA is at an all-time high, with 55 percent of Americans in favor of the law as of February 2020. As the nation faces the 2020 election, concerns over health care quality and cost continues to be a top concern among voters as it was in the 2018 midterm elections, which played a significant role in House Democrats winning the majority. At least six in ten voters now say that health care and the economy are very important to their 2020 vote choice, ahead of foreign policy or national security, taxes, immigration, climate change, and international trade and tariffs.

In several swing states, including Michigan, Pennsylvania, and Wisconsin, voters are more likely to support the stability of the ACA over proposals like Medicare for All and repealing and replacing the ACA. Notably, most Democrats and Democratic-leaning independents also prefer to expand the ACA rather than replace the law with a Medicare for All plan. While most Republican voters still hold unfavorable views on the ACA, only three percent say they are in favor of repealing the law – a considerable decrease from the 2016 election in which 18 percent of Republican voters at the time mentioned opposition to the ACA or repealing the ACA as their top concern.

While the country continues to experience economic setbacks due to the COVID-19 pandemic, newly unemployed Americans are turning to the Medicaid program for health insurance. A majority of adults now say that the Medicaid program is personally important to them and their families, and about one in four adults who are not currently on Medicaid say that it is likely they or a family member will turn to Medicaid for health insurance in the next year.

This is the first time that the country is experiencing an economic recession since the ACA was implemented, while also dealing with the uncertainty of a global pandemic and an upcoming national election. The ACA has significantly improved health coverage and outcomes for millions of Americans and it is crucial to continue to build on the gains the law made in affordable coverage for low and middle-income consumers.

TABLE OF CONTENTS
ACA Report

PRE-ACA HEALTH CARE

Prior to the implementation of the Patient Protection and Affordable Health Care Act (ACA), the U.S. health care system was ranked last among industrialized nations in terms of affordability and patient access to health care.[1] Americans faced higher insurance premiums, high prescription drug costs, and overall less access to care.

Millions of Americans could not access critical benefits through individual or small group coverage. Patients typically faced unexpected limits on services that were technically covered by their health insurance plans, leaving them to pay for the remainder of the cost. Prior to the law's implementation, in the individual market, more than 60 percent of patients did not have access to maternity coverage, 30 percent did not have coverage for substance use treatment, nearly 20 percent did not have coverage for mental health care services, and almost 10 percent did not have coverage for prescription medications.[2]

Patients were also subjected to the uncertainty of high insurance rates and limited plan choices based on the insurer's consideration of a patient's health or health history, or what are known as pre-existing conditions. Insurers could require information about the health of applicants for coverage through the medical underwriting process, where non-group applicants were required to answer a lengthy questionnaire about their health and health history, and were often required to provide authorization for the insurer to access their medical records. In most states, insurers in the individual market were then permitted to use this information to decline coverage, offer reduced coverage, or accept individuals under higher premiums.[3]

Prior to the ACA, nearly 52 million adults under age 65 have a preexisting health condition that likely would have prevented them from purchasing individual health insurance[4]. For individuals purchasing health insurance, there were also a broad range of rate classifications based on their health status, occupation, duration of policy, how the policy was purchased, and other factors, all of which contributed to the high cost of health insurance. While federal law at the time did provide some version of transitional coverage for individuals who lost their employer coverage through the Health Insurance Portability and Accountability Act (HIPAA), eligibility was based on having 18 months prior coverage during which there was no gap in coverage longer than 63 days.

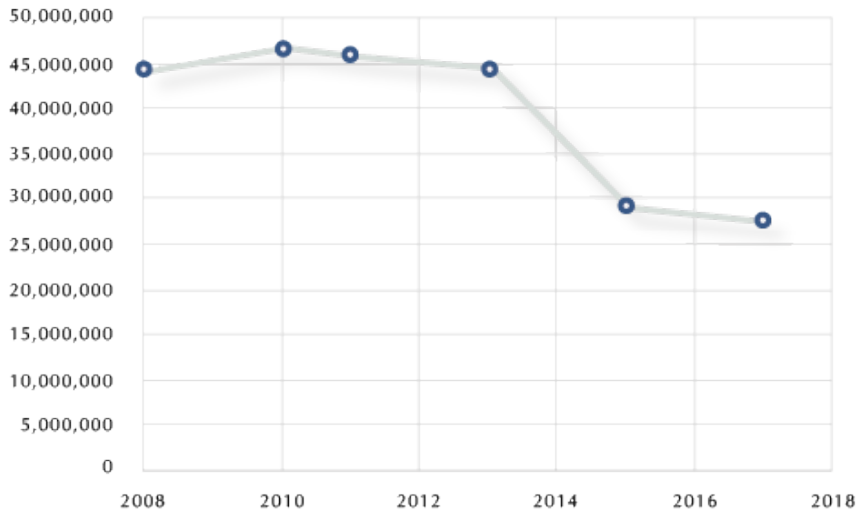
How the ACA Benefits Patients

The ACA has provided Americans a range of health care benefits and protections that have boosted health insurance affordability and coverage, increased access to preventative care services, cut health care costs and health care delivery inefficiencies, and reduced socioeconomic and racial health disparities.

Marketplace Coverage

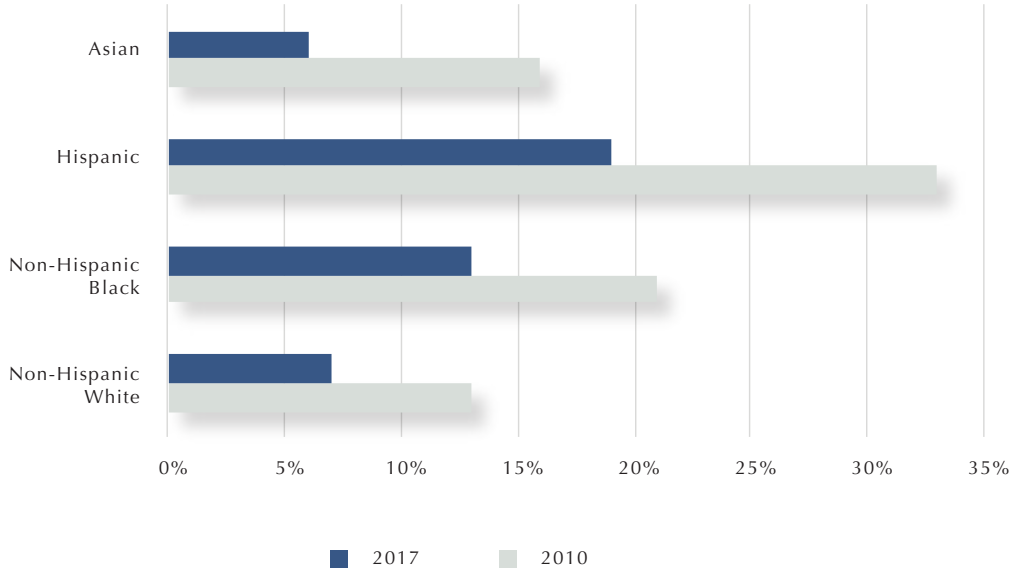
After the ACA was signed into law and key provisions were implemented, the number of uninsured had dropped to historic lows, and nearly 20 million Americans gained health insurance coverage through the law's expansion of public and private insurance.

Number of Uninsured



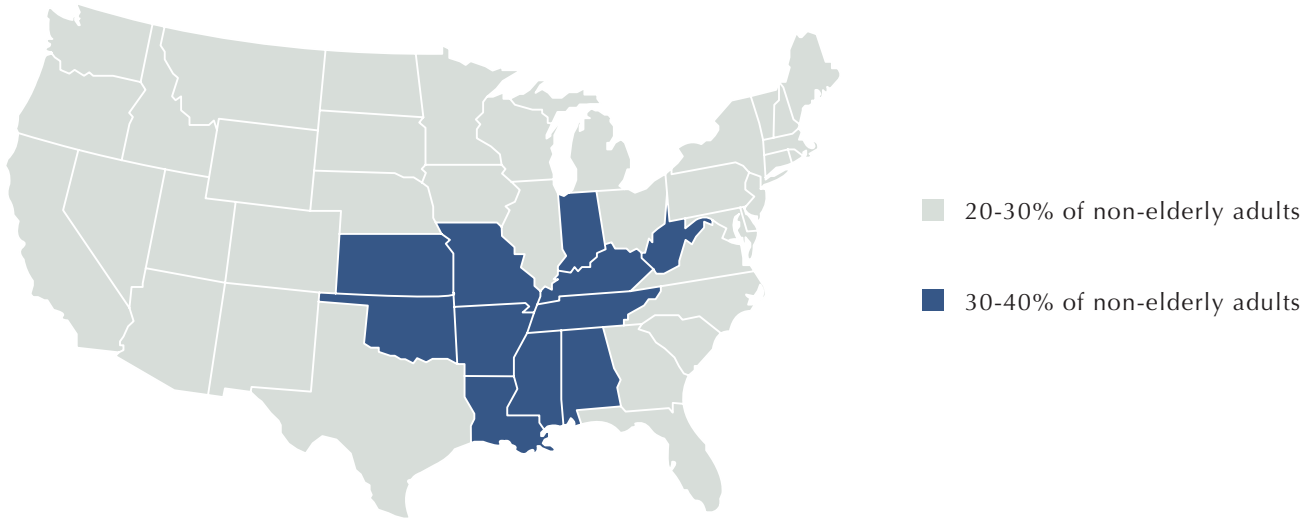
Notably, groups that typically had high uninsured rates rapidly gained coverage, including young adults, people of color, and low-income people, particularly in states that opted to expand Medicaid.[5]

Comparing Uninsured Rates



One of the most important provisions of the ACA is the guarantee that health insurers cannot deny coverage or charge higher premium rates based on an individual's pre-existing conditions. Approximately 54 million Americans, or 27 percent of all adults under 65, have a pre-existing condition that likely would have made them uninsurable or forced to pay higher premiums in the individual market prior to the enactment of the ACA[6]. Below is a map illustrating the percent of non-elderly adults who would have been denied coverage or forced to pay higher insurance premiums due to pre-existing conditions prior to the implementation of the ACA[7]:

Non-Elderly Adults Potentially Facing Denial of Insurance Pre-ACA



The ACA also provided young adults with access to coverage through the dependent coverage provision, which guaranteed that they could stay on their parent's insurance plan until age 26. This resulted in 2.3 million young adults gaining coverage – a group that was typically less likely to have had employer sponsored insurance. They were also able to gain coverage both through the ACA's Medicaid expansion and through marketplace financial assistance.[8]

The ACA also simplified the enrollment process for health insurance for the non-group market. The benefits offered are the same for all policies within a state within four different tiers of costs: bronze, silver, gold, and platinum. Additionally, the ACA offers replacement coverage in the non-group market for individuals who lose eligibility for group coverage without their health status as part of the consideration.

Medicare, Medicaid, and CHIP

The ACA made a number of significant changes to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) that have had longstanding positive effects on all three programs.

Medicare

The ACA made changes to the Medicare program by shifting from a fee-for-service based payment model to a focus on increasing provider accountability over the quality and cost of health care services [9]. This shift was marked through the creation of the Center for Medicare and Medicaid Innovation (CMMI), an organization of

the U.S. government under the Centers for Medicare and Medicaid Services (CMS) tasked with creating new payment models to boost the value of care for Medicare beneficiaries.

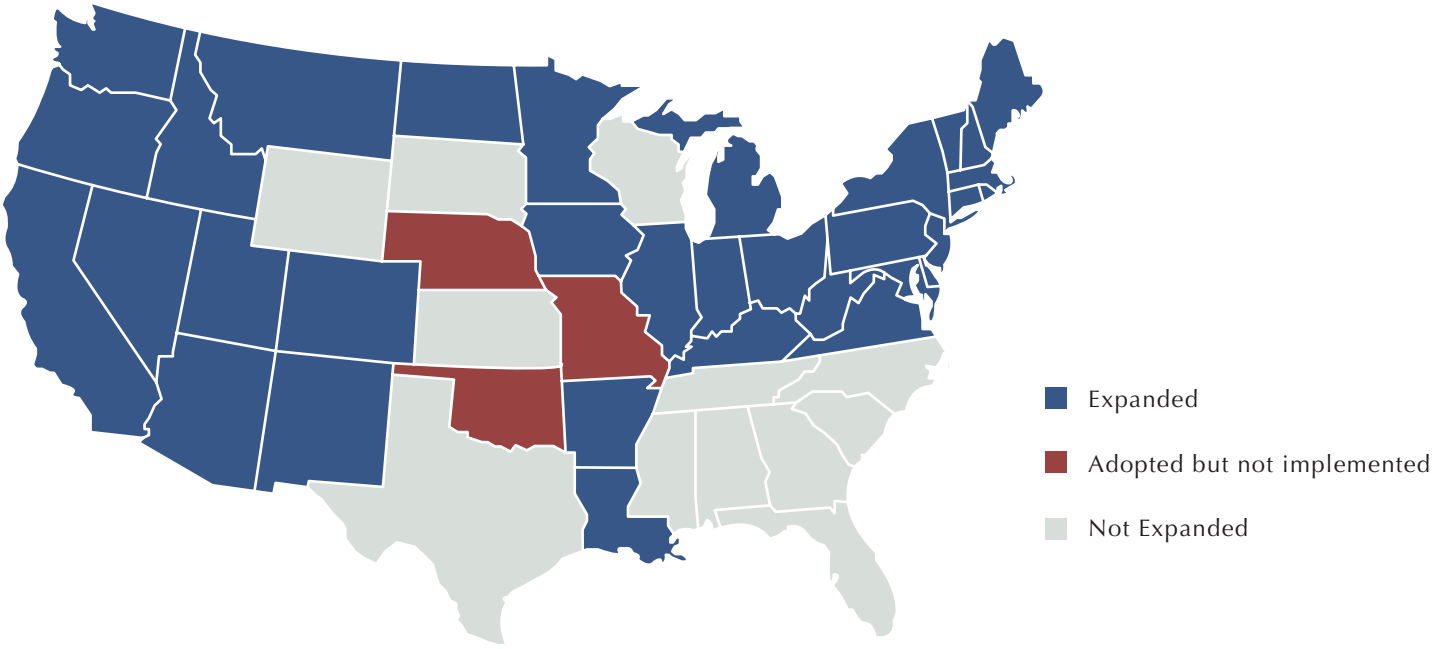
The law also made significant changes to the Medicare Advantage (MA) program where enrollees can choose to receive their Medicare benefits from private plans. The law constrains payment rates in MA plans until they are on par with plans offered in traditional Medicare, with financial rewards available to plans that receive high performance ratings. These financial rewards were designed by the ACA to help incentivize the MA plans to improve quality and affordability for patients.

Medicare beneficiaries now also receive free coverage for some preventative benefits, such as screenings for breast and colorectal cancers, cardiovascular diseases, and diabetes. Additionally, the ACA has been closing the Medicare Part D drug benefit coverage gap, or what is known as the "doughnut hole." Prior to the ACA, beneficiaries were responsible for all drug costs while in this coverage gap, which would occur when a prescription drug expense exceeded the initial coverage limit of Part D plans but did not yet reach the catastrophic level of coverage. As of 2019, the coverage gap has closed for brand-name drugs, with Medicare enrollees paying 37 percent of the cost of generic drugs while in the coverage gap.[10]

Medicaid

The ACA also made a number of changes to Medicaid, the most notable being that it expanded Medicaid coverage for adults with incomes up to 138 percent of the federal poverty level (FPL) [11]. This provision was originally a requirement in the law, but became optional after the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius[12]. To date, 39 states, including the District of Columbia, have expanded Medicaid, and 12 states have not[13]:

Medicaid Expansion Status



Medicaid expansion under the ACA has led to significant coverage gains and reductions in uninsured rates, and has resulted in expanded access to affordable care, utilization of services, and financial security for low-income and other vulnerable populations. The expansion has also had positive effects for state budgets and revenues, boosting overall economic growth in these states and localities by offsetting state costs in other budget areas.[14]

Childrens Health Insurance

In addition to the positive changes and outcomes as a result of the ACA on the Medicare and Medicaid programs, the law also strengthened the Children's Health Insurance Program (CHIP), specifically in areas of enrollment, eligibility, and financing.

Primarily, the ACA expanded Medicaid eligibility for children to 138 percent FPL and established tax credits and options for coverage under the new health insurance marketplaces[15]. Notably, about one-quarter to one-third of enrollees under Medicaid expansion through the ACA are children. The ACA also included pediatric dental and vision care as part of the law's essential health benefits, ensuring that children are covered through both the ACA marketplace and Medicaid for those services.[16]

Prescription Drugs

The ACA expanded prescription drug coverage in several ways, primarily by requiring plans to cover at least one drug in each drug class and to count out-of-pocket drug expenses toward a beneficiary's deductible. The law also expedited the FDA approval process for biosimilar drugs, which are comparable to generic versions of branded drugs.

Additionally, through the ACA's Medicaid expansion and the broadening of the Medicaid Drug Rebate Program, low-income Americans gained better access to brand-name and generic drugs and lowered costs for taxpayers. The law also expanded the 340B drug pricing program, which provides prescription drugs at discounted prices for certain health care providers, critical access hospitals and rural referral centers.[17]

Prevention and Public Health Initiatives

Advancing public health measures and funding has been a significant contribution of the ACA. The law requires that health plans in the individual and small group markets cover essential health benefits (EHBs). EHBs include items and services in ten categories[18]:

- Ambulatory patient services (outpatient services)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services including behavioral health treatment
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management and
- Pediatric services, including oral and vision care

The ACA effectively eliminated the caps on the amount of coverage patients receive for these specific EHBs, which contributed to lower health care costs and less financial burden for the patient.

The ACA also established the National Health Council within the Department of Health and Human Services (HHS) to help coordinate and execute the federal government's efforts on prevention, wellness, and health promotion. The Council is responsible for making policy recommendations to the President and Congress to advance public health initiatives[19].

While the Council is charged with coordinating these policy recommendations and federal programs, the law also established the Prevention and Public Health Fund-- the nation's first mandatory funding system dedicated to improving the U.S. public health system. The fund provides expanded and sustained national investments in prevention and public health to improve health outcomes and to enhance health care quality[20]. The creation of this fund is a key component of the law's intent to refocus the U.S. health care system toward prevention and wellness, with the ultimate goal of cutting the cost of chronic disease.

The funding for this program is a critical component of the Centers for Disease Control and Prevention's (CDC) budget. In fiscal year (FY) 2020, Congress directed $854 million to the CDC for activities to address critical public health priorities, including heart disease, diabetes prevention and tobacco control, with remaining funds allocated to the Substance Abuse and Mental Health Services Administration and the Administration for Community Living's Administration on Aging[21].

Healthcare Delivery and Quality

The ACA took broad steps toward improving the ways in which health care is delivered in the U.S. by refocusing health systems toward value-based care. One of the key provisions that led to delivery system reforms was the creation of a research and development-based program, the Center for Medicare and Medicaid Innovation (CMMI), an organization under the Centers for Medicare and Medicaid Services (CMS). The CMMI is responsible for designing and implementing new payment and service delivery models to lower health care costs, improve the quality of care, and mitigate inefficient spending, particularly within Medicare, Medicaid, and the Children's Health Insurance Program[22].

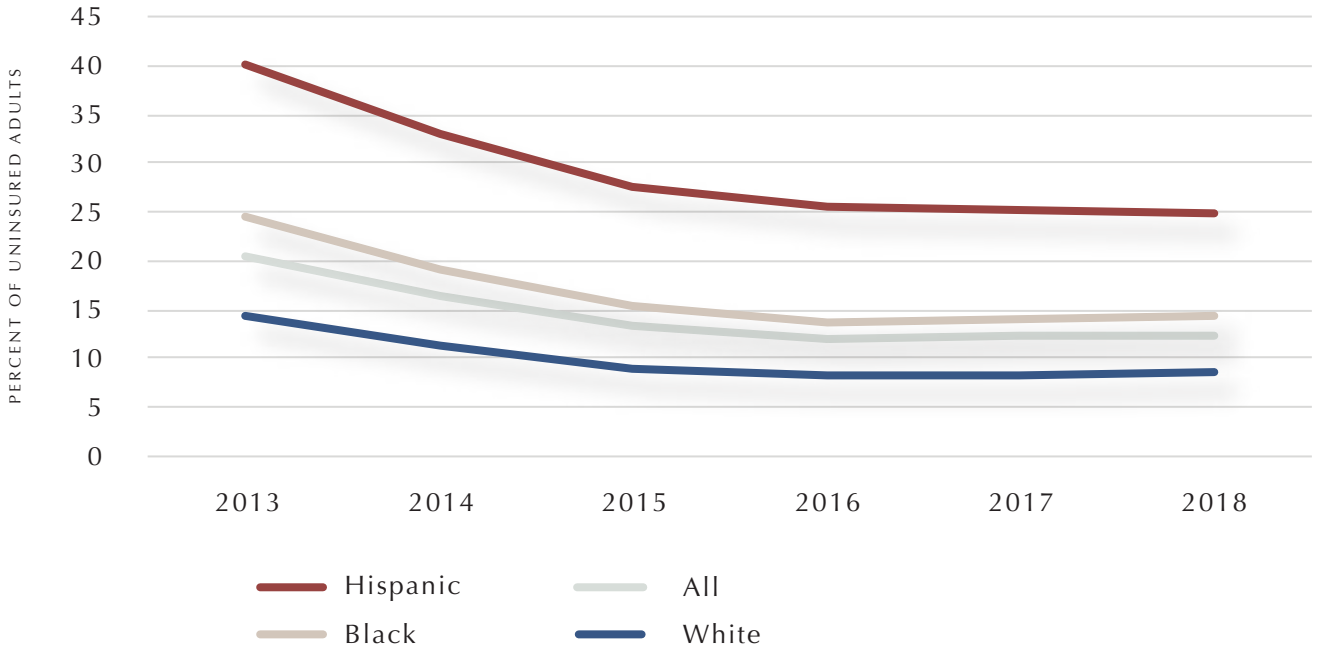
As of 2018, the CMMI has produced over 40 new payment models, mostly within Medicare, and is testing payment models within Medicaid and CHIP. Prior to the ACA, Congressional action was needed to boost innovation and the expansion of demonstration programs, which were typically delayed or blocked.

The enhancement of Accountable Care Organizations (ACOs) within the CMMI, which facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce costs, has also been a critical aspect of improving quality care delivery through the ACA[23]. ACOs are organizations of health care providers that focus on quality, cost, and overall care of Medicare beneficiaries. These organizations are comprised of physicians, partnerships or joint venture arrangements between hospitals and physicians, hospitals employing physicians, and other forms of organizations that the Secretary of Health and Human Services deems appropriate[24]. The implementation of ACO's has demonstrated that creating accountability for providers for the cost and quality of their patients' care has led to a boost in the value of these services.

Health and Socioeconomic Disparities

Disparities in social, economic, and environmental conditions continue to impact the health outcomes of low-income populations and communities of color in the U.S., which has the largest socioeconomic disparities in health care of any wealthy country[25]. The ACA has substantially improved affordability and access to quality care for these communities, in states that both expanded Medicaid and those that did not, with larger gains made in the expansion states.

Uninsured Adults by Race and Ethnicity[26]



Under the ACA, new health insurance options were made available, including the availability of subsidies, essential health benefits, and the elimination of annual or lifetime dollar limits, particularly for those who were uninsured, a group that is comprised primarily of African American and Hispanic populations. The gap in insurance coverage between individuals in households with annual incomes below $25,000 and those in households with incomes above $75,000 was reduced by 46 percent in expansion states and 23 percent in non-expansion states[27].

Key Provisions of the ACA

Below is a high-level list of some of the key provisions of the ACA

Requires employers to provide health insurance coverage to their employees, or pay penalties

Create state-based American Health Benefit Exchanges through which individuals can purchase coverage

Prohibits insurers from rating or denying coverage based on an individual's pre-existing conditions

Expands Medicaid coverage for adults with incomes up to 138 percent of the federal poverty level (FPL), and expanded Medicaid eligibility for all children up to age 19 to 138 percent FPL

Requires insurance plans to provide coverage for children until the age of 26 under their parents' policy

Prohibits health plans from putting annual or lifetime dollar limits on most benefits

Requires individual and small group health plans to cover essential health benefits (EHBs) such as preventative health services, maternity care, mental health services, and pediatric dental care

Requires insurance plans to cover certain preventive care services without cost-sharing, such as immunizations, preventive care for children, and screening for adults for conditions such as high blood pressure, high cholesterol, diabetes and cancer

Provides options for states to create "health homes" for Medicaid enrollees with multiple chronic conditions

Requires data collection and reporting to address health disparities based on ethnicity, geographic location, gender, disability status, and language

Boosts investments in health information technology

Improves care coordination for patients who quality for both Medicare and Medicaid

Coverage and Unemployment

As the COVID-19 pandemic has accelerated in the U.S., a sharp increase in unemployment has reached historically unprecedented levels, with nearly 31 million Americans currently unemployed. As millions of Americans experience job loss, they will also lose their employer sponsored health insurance (ESI). Some workers who lose their jobs could retain coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA), but that requires workers to pay the full premium and a two percent administration fee, proving an expensive option given their reduced incomes[28].

Those who lost coverage due to job loss are able to purchase health insurance through the ACA marketplaces, as well as potentially qualify for financial assistance with premiums and cost-sharing responsibilities within 60 days of their unemployment[29]. Under the ACA, job loss is a qualifying life event that enables individuals to access this coverage and financial assistance outside of the annual enrollment period.

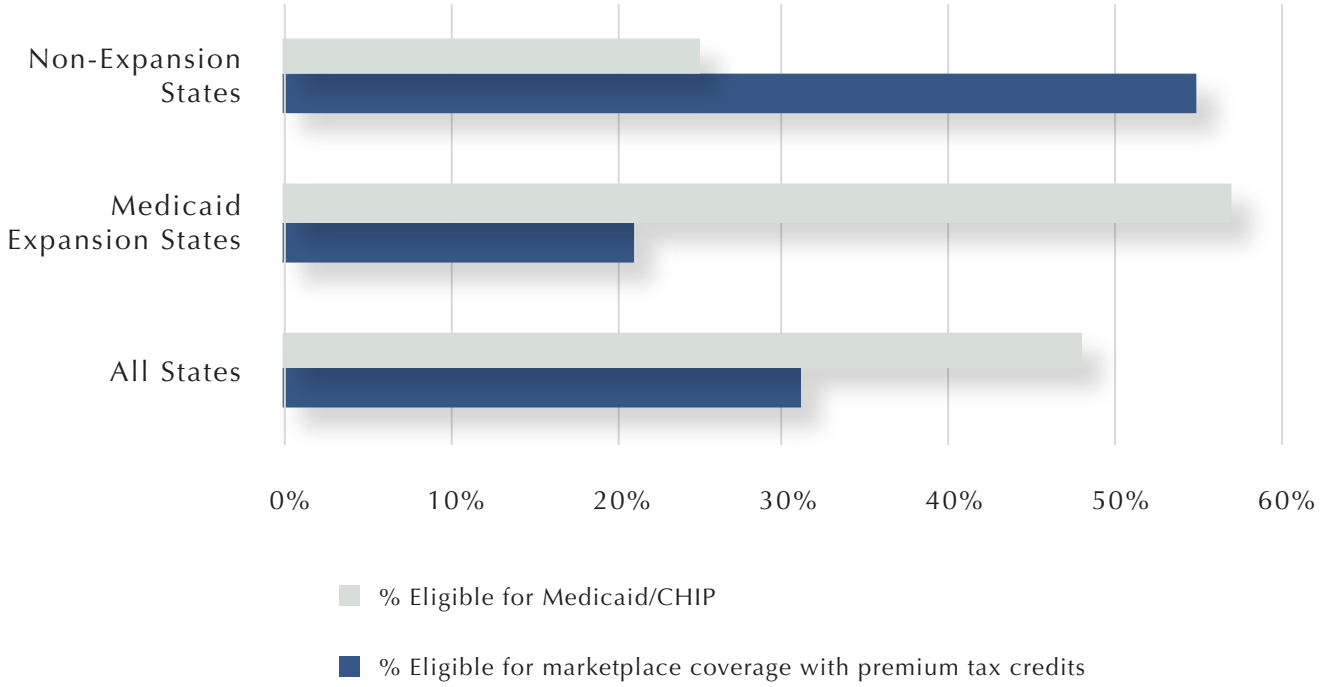
Some states that opted to have their own insurance exchanges set up through the ACA have created a special enrollment period during the COVID-19 pandemic. These state-based marketplaces (SBM) would allow their constituents to sign up for health insurance through the ACA marketplace without a qualifying event to enroll[30]. To date, 12 of the 13 states that have SBMs have set up a new COVID-19 special enrollment period, allowing the uninsured to enroll for coverage outside of the annual enrollment period[31]. The Trump administration declined to establish a similar special enrollment period for the pandemic for states relying on the federal marketplace platform, reducing enrollment opportunities in 38 states.

As of June 2020, roughly 487,000 people signed up for an ACA insurance plan after losing their ESI since the last open enrollment period that ended in December 2019, which is a 46 percent increase in sign-ups compared to the same period last year[32].

Americans who lost their ESI are also able to sign up for health coverage through Medicaid. While the ACA has boosted health insurance coverage through the expansion of Medicaid eligibility, Americans living in non-expansion states fall into a coverage gap because their incomes are above Medicaid eligibility qualifications, but are also below the poverty level, which is the lower limit for marketplace premium tax credits. Nationally, over two million uninsured adults fall into this coverage gap that results from state decisions not to expand Medicaid[33].

As more people lose their jobs and accompanying ESI, more may fall into this coverage gap, particularly starting in 2021 after unemployment benefits expire for many who have lost their jobs, and incomes are likely to drop below the minimum threshold for marketplace subsidies.

Individuals Eligible for Medicaid Coverage Who Recently Lost Their Employer Sponsored Insurace[34]



This will be the first time that the country will experience an economic recession since the ACA was implemented, which provides a stable safety net for Americans who lose their employer sponsored health insurance and who are experiencing declines in income.

COVID-19 Testing, Treatment, and Vaccination Under the ACA

All forms of public and private insurance, including self-funded plans, must now cover FDA-approved COVID-19 tests and costs associated with diagnostic testing with no cost-sharing, as long as the test is deemed medically appropriate by an attending health care provider as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act[35]. Per CMS, there is also no limit to the amount of COVID-19 tests that an insurer or plan is required to cover for an individual as long as each test is deemed medically appropriate, the individual displays COVID-19 symptoms, or has had known or suspected exposure to the virus[36].

In addition, Medicare, Medicaid and private plans are required to cover serology tests that can determine if the patient has been exposed to COVID-19 and developed antibodies. The Families First Coronavirus Response Act that was recently passed by Congress included an option for states to cover testing for the uninsured through Medicaid with 100 percent federal financing[37].

While the government has addressed coverage for COVID-19 testing, there has not yet been any federal legislation to address the cost of treatment for COVID-19. The treatment costs associated with COVID-19 currently depend on the type of coverage an individual has, and could be expensive for those who become hospitalized or critically ill, especially for the uninsured and underinsured.

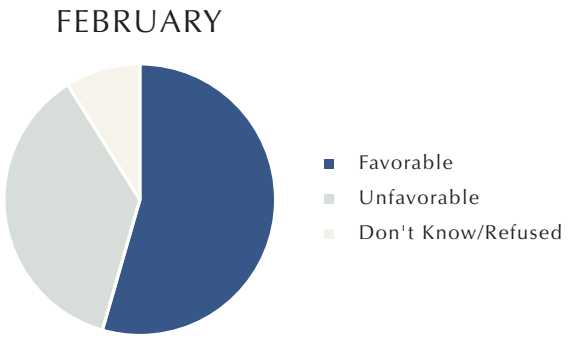
Meanwhile, the financial stability of hospitals and health systems across the country that have had to transform how they provide care has been significantly impacted. These facilities have seen an unprecedented surge in patients, which has required the cancellation of nonemergency elective surgeries and the delay of care due to patients adhering to social distancing requirements. Additionally, treatment for the virus has created an extraordinary demand for medical equipment and supplies, disrupting supply chains and increasing the costs that providers face to treat COVID-19 patients[38]. The financial toll that hospitals and health systems are facing would be even steeper without the ACA, as they would have incurred even more unreimbursed costs for providing care to a higher number of uninsured patients.

When a vaccine for COVID-19 is eventually approved, it will most likely be covered for nearly all insured people without cost-sharing, under the ACA requirement that federally-recommended preventative care be covered without cost-sharing for anyone enrolled in private insurance, Medicare, or in the Medicaid expansion.

PUBLIC PERCEPTION OF ACA

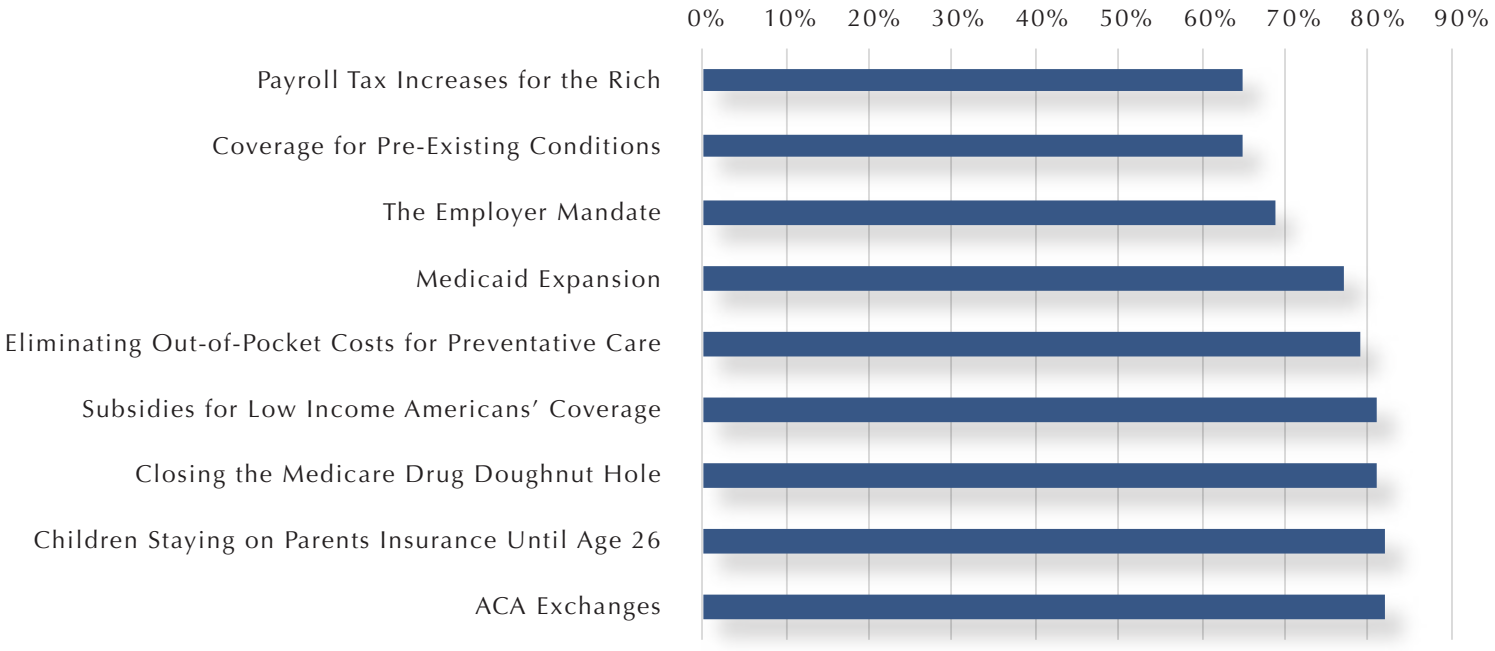
Public opinion of the ACA has evolved over time and has steadily improved since the law's enactment in 2010. Initially, as key provisions of the ACA were implemented between 2010-2013, public opinion was narrowly divided and deeply partisan. However, after the failed repeal and replace efforts in Congress and the COVID-19 pandemic, the law has seen a boost in public support. As of February 2020, nearly 55% of Americans viewed the law favorably as opposed to roughly 37% who had unfavorable views[39].

Voters Who Favor the ACA



Some of the most popular provisions of the ACA garner significant support among voters regardless of party affiliation. Per a poll from the Brookings Institution on support for nine major provisions of the ACA, children staying on parents' insurance until age 26 and the ACA exchanges were the most popular, with 82 percent supporting the provision. Closing the Medicare drug doughnut hole and subsidies for low income Americans' coverage also received significant support with 81 percent[40].

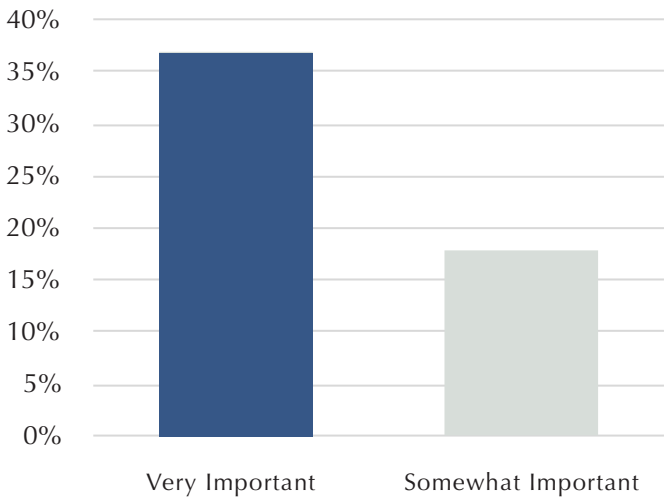
Public Support for Elements of the ACA



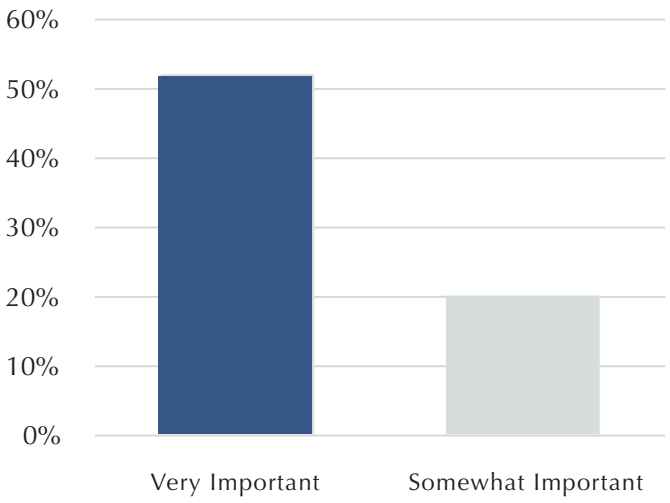
While the country continues to experience economic setbacks due to the COVID-19 pandemic, newly unemployed Americans are turning to the Medicaid program for health insurance. A majority of adults now say that the Medicaid program is personally important to them and their families, and about one in four adults who are not currently on Medicaid say that it is likely they or a family member will turn to Medicaid for health insurance in the next year. Additionally, Democrats and Independents are more likely than Republicans to say that Medicaid is important to them[41].

Adults Who Say Medicaid is Important to Them and Their Family

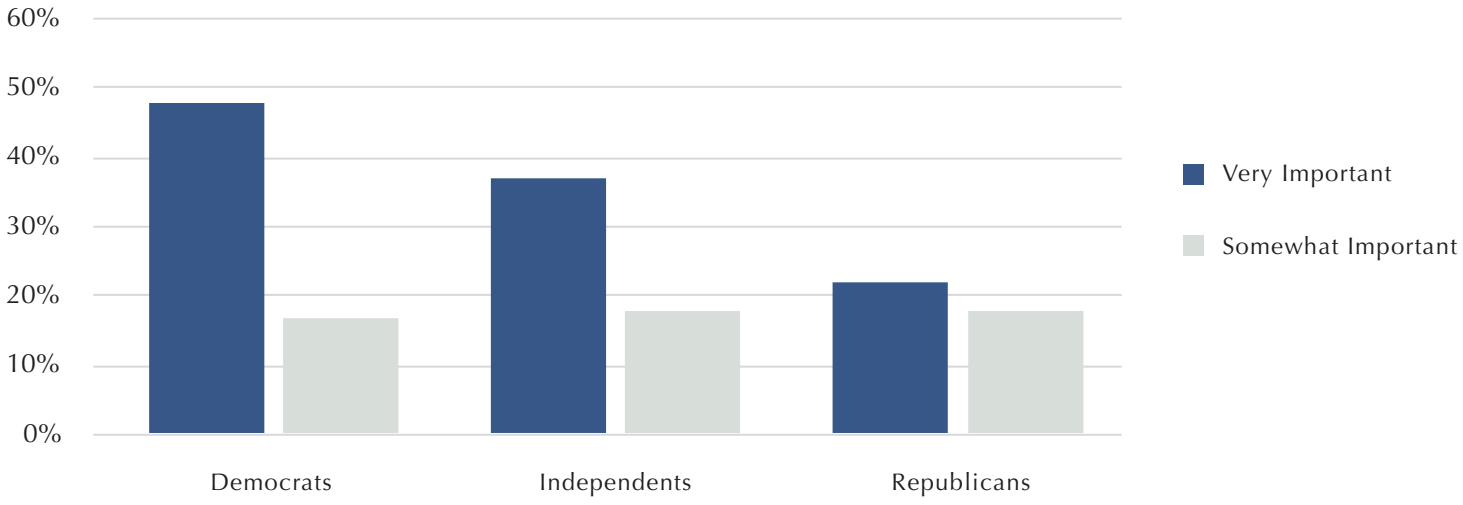
PERCENTAGE OF ADULTS



CONNECTION TO MEDICAID

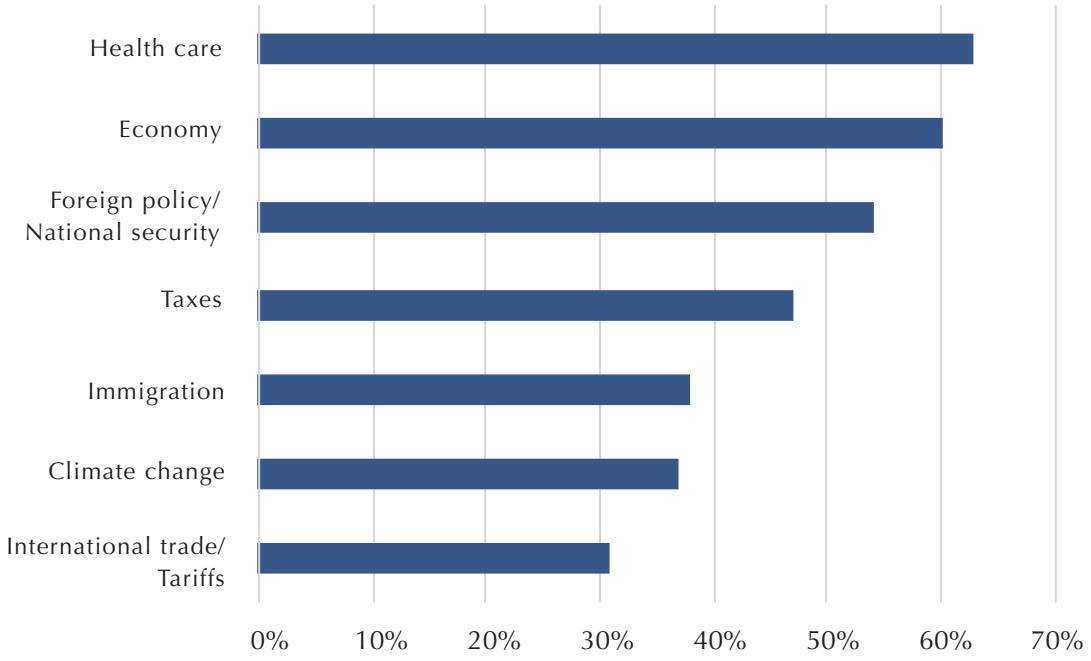


POLITICAL AFFILIATIONS



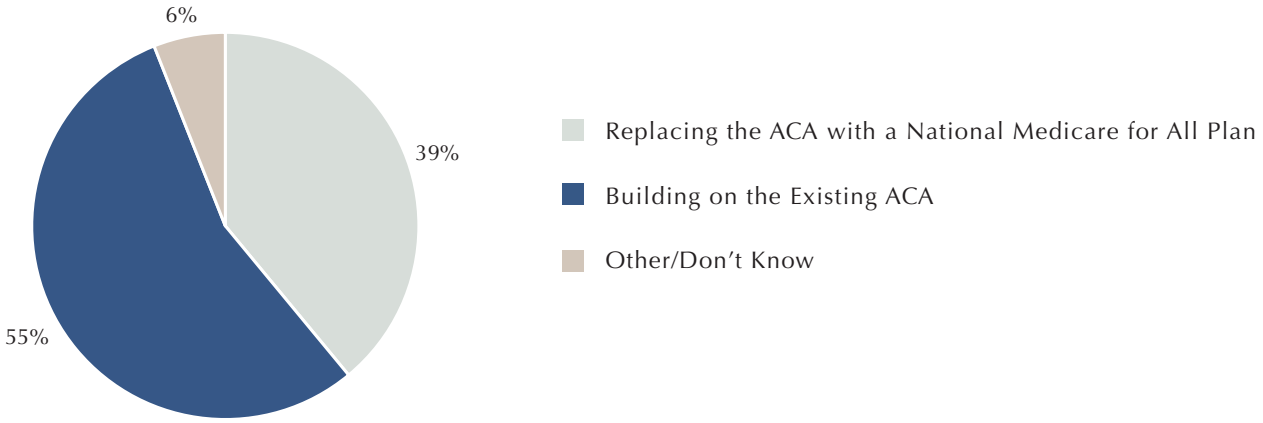
As the nation faces the upcoming 2020 election with the uncertainty of the COVID-19 pandemic, concerns over affordable and quality health care remain a top concern for voters. At least six in ten voters now say that health care and the economy are very important to their 2020 vote choice, ahead of foreign policy or national security, taxes, immigration, climate change, and international trade and tariffs[42].

Top issues for voters:



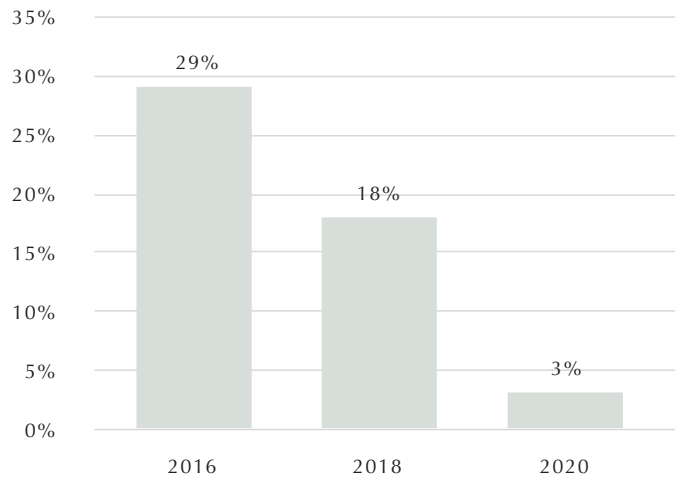
Most Democrats and Democratic-leaning independents would prefer to expand the ACA rather than replace the law with a Medicare for All plan, per a 2019 tracking poll from Kaiser Family Foundation[43].

Democrats and Leaning-Democrats Prefer Building on the Existing ACA



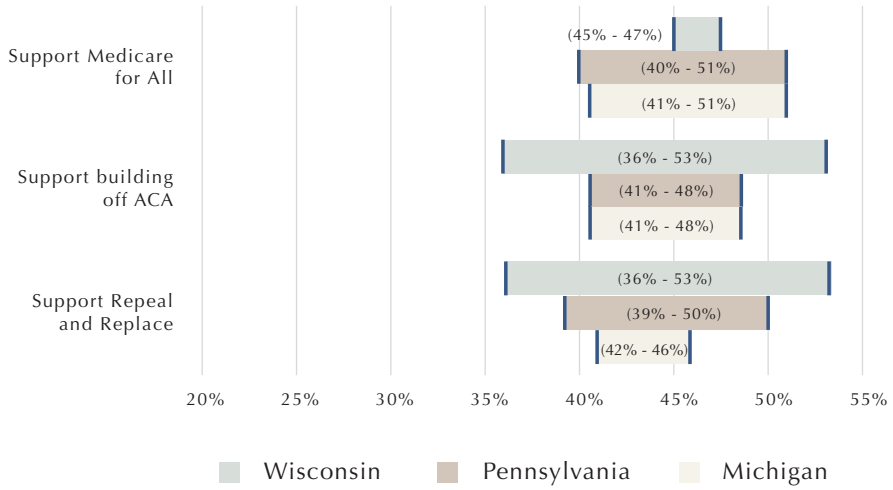
Meanwhile, Republican voters are expressing increasing concerns over health care, and are prioritizing other health care issues over repealing the ACA, including health care costs and access to health care. While most Republican voters still hold unfavorable views on the ACA, only three percent say they are in favor of repealing the law – a considerable decrease from the 2016 election in which 18 percent of Republican voters at the time mentioned opposition to the ACA or repealing the ACA as their top concern[44].

Republican Voters Who Oppose the ACA and Want to Repeal



In several swing states, including Michigan, Pennsylvania, and Wisconsin, voters are more likely to support the stability of the ACA over proposals like Medicare for All and repealing and replacing the ACA. Per a Third Way poll in January 2020 in these three states, the ACA outperformed Medicare for All by 17 points in Michigan, 18 points in Pennsylvania, and 15 points in Wisconsin. Those who are strongly opposed to Medicare for All are double the number who are strongly in favor in Pennsylvania (43% to 21%), Michigan (42% to 22%), and Wisconsin (37% to 22%)[45].

Voters in MI, PA, WI who oppose or are split on Medicare for All, Repeal and Replace, and supporting the ACA



In the 2018 midterm elections, voter concerns over health care played a significant role in House Democrats winning the majority. The issue considerably mobilized Democrats after the 2017 efforts in Congress to repeal and replace the ACA, and the fear of losing ACA benefits like protections for preexisting conditions and coverage for children under age 26. Voters across the country consistently ranked health care as the number one issue of concern. Per a Kaiser Family Foundation poll in October 2018, 71 percent of voters said health care was very important to making their decision about who to vote for in Congress that year, with 30 percent saying that it was the most important issue[46].

CONGRESSIONAL AND ADMINISTRATION ACTION ON THE ACA

Efforts to Repeal, Replace, and Defund the ACA

Since the enactment of the ACA in 2010, Congress has remained deeply divided over the law's implementation. Multiple Congresses and different presidential administrations have intensely debated the law, which has been repeatedly subjected to bills to amend, delay, defund, or repeal it entirely.

Throughout the 112th to 114th Congresses, the Republican-led House passed numerous bills related to the ACA, including to repeal the law in its entirety. Debate of the law was less frequent in the Senate, particularly in the 112th and 113th Congresses, which remained under Democratic control and rarely considered House-passed bills regarding health care[47].

During the 114th Congress when Republicans were in control of both chambers, they utilized the budget reconciliation process to attempt to repeal parts of the ACA. In 2015, the House passed a reconciliation bill, H.R. 3762, the Restoring Americans' Healthcare Freedom and Reconciliation Act, which would have repealed parts of the ACA and ended funding for Planned Parenthood. Specifically, the bill would have eliminated the financial penalty for individuals who did not purchase health insurance, otherwise known as the individual mandate. The bill would have also terminated the premium tax credits and reduced cost-sharing, and Medicaid expansion and essential health benefits would have been significantly rolled back. After the Senate amended the bill and passed it through the budget resolution, President Obama vetoed the legislation on January 8, 2016.

Republicans then used the passage of the bill for messaging on health care issues in the 2016 election. Throughout the election, President Donald Trump campaigned on repealing and replacing the ACA. Immediately after President Trump was sworn into office, he issued an executive order to minimize the economic and regulatory burdens of the ACA, with instructions for agencies to exercise all authority and discretion available to delay the implementation of any provision or requirement of the ACA that would impose a financial burden[48].Over the course of the Trump administration and the 115th Congress, efforts to repeal and replace the law accelerated.

After President Trump began his term, the Republican-led House passed the American Health Care Act (AHCA) in an attempt to repeal and replace the law without support in the Senate. The Senate then introduced their own version of a repeal and replace bill, the Better Care Reconciliation Act (BCRA), which would have capped Medicaid spending and repealed the taxes that pay for ACA benefits. After an initial CBO report specifying that the BCRA would result in 22 million more uninsured by 2026 and increase premiums, the Senate released a revised version of the BCRA. The CBO then released another estimate of the revised BCRA with 22 million more uninsured by 2026.

In an effort to revive negotiations, a "skinny" repeal bill was then released, which would have repealed the individual and employer mandates and given states broad authority to waive sections of the law. The CBO then released a third report, estimating that the skinny repeal proposal would result in 16 million more people without insurance coverage in 2026 with an average 20 percent increase in premiums for individual policies purchased through the marketplaces or directly from insurers. In a historic vote, Senator John McCain (R-AZ),

who delayed the initial vote of the bill due to treatment for illness and a week earlier voted to proceed to debate, became the deciding vote to end the repeal and replace legislation. Efforts to repeal and replace the law continued on a less frequent basis, until Congress passed major tax reform legislation that repealed the ACA's individual mandate at the end of 2017.

Following Congress' unsuccessful efforts to repeal and replace the ACA in 2017, the Trump administration began to accelerate its efforts to change the law. These efforts have been expansive, and have included removing key information about the law from government websites; slashing funding for programs to assist with enrollment and halving the annual enrollment period; encouraging the proliferation of short-term health plans; finalizing rule changes for the individual market that weakened standards for benefits and allowed states to scale back benefits and weakened risk adjustment, and radically changed immigration policies around public charge.

Ultimately, the efforts by Congress and the Trump Administration to weaken or repeal the ACA has resulted in lower enrollment, weakened consumer protections in the marketplaces, encouraged the purchase of substandard plans, and raised premiums[49].

Efforts to Stabilize the ACA

In the midst of the intense debate over the repeal and replace efforts in 2017, there have been several administrative and bipartisan legislative efforts to address changes and stabilize the ACA.

In 2017, Senators Lamar Alexander (R-TN) and Patty Murray (D-WA) sponsored hearings in the Senate Committee on Health, Education, Labor, and Pensions (HELP) on bipartisan solutions to stabilize private health insurance markets. The Problem Solvers Caucus, comprised of House Democrats and Republicans, also worked together on a package of reforms to the law to help stabilize the individual market and create incentives for providers to lower costs and enhance state flexibility[50].

Additionally, Congress approved and President Obama signed several bills that aimed to improve the ACA, including the Protecting Affordable Coverage for Employees (PACE) Act to protect businesses with 51-100 employees from ACA rules that would have led to premium increases of 18%, impacting 150,000 businesses and 3 million workers[51]. Some of the health taxes were also delayed, including the Cadillac tax, the medical device tax, and health insurance taxes and were later repealed entirely in late 2019.

Many changes were also made by the Obama administration, including a tax penalty pass where taxpayers who filed returns based on inaccurate subsidy data from the federal government would not be required to repay the government if they received a large subsidy, changing annual limits on employee cost-sharing, and allowing states operating their own exchanges to use money from federal grants to do outreach and education to increase enrollment, even though the ACA stipulates the grants are to be used only to set up exchanges[52].

There have been several bills passed in the Democrat-led House in the 115th Congress to enhance and improve the ACA. Most recently, Democrats in the House passed H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, a bill to stabilize and expand the ACA. The bill would improve and expand marketplace affordability and availability of ACA subsidies to additional income brackets, boost premium tax credits, increase funding for state-based reinsurance programs, create funding for states to create their own marketplaces, and rescind guidance on 1332 waivers[53].

LEGAL CHALLENGES TO THE ACA

The NFIB v. Sebelius case in 2012 was the beginning of several legal challenges the ACA has faced since its enactment, when the Supreme Court upheld the ACA's individual mandate, or the financial penalty for not having health insurance. The Court held that Congress lacked the authority under the Commerce Clause in the Constitution to require individuals to buy health insurance, but could be upheld under Congress's taxing authority as a tax penalty.

In 2017, Congress passed a tax bill that partially repealed the ACA's individual mandate. Republicans have argued that this lack of a tax that was meant to satisfy the individual mandate has made it unconstitutional, thereby making the entirety of the ACA unconstitutional. Democrats have argued that because Congress voted to repeal this part of the mandate, and not the entire ACA, Congress clearly intended to maintain the rest of the law.

Following the passage of the tax bill, 20 states went on to sue the federal government to challenge the constitutionality of the ACA's individual mandate in the Texas v. Azar case. In 2018, the District Court held that the ACA must be struck down in its entirety as the individual mandate was made invalid by Congress's vote to repeal the penalty, and would not produce revenue for the government. After the District Court issued their decision, four states and the U.S. House of Representatives appealed the decision to the U.S. Court of Appeals for the Fifth Circuit.

The U.S. Court of Appeals for the Fifth Circuit then issued its decision in Texas v. United States in 2019, and held the unconstitutionality of the individual mandate but reversed the District Court's earlier decision that the individual mandate cannot be severed from the ACA[54]. This ruling effectively preserved the ACA without the mandate and sent the case back down to the District Court to determine how much, if any, of the remainder of the ACA should exist.

California then filed a petition to the U.S. Supreme Court with 21 state attorneys general to hear the case and expedite the hearing schedule to determine the fate of the ACA. The court also accepted a cross-appeal by Texas and other states opposing the ACA for the law to be struck down and asked the court to deny the request from California to expedite the hearing of the case. The Supreme Court then announced that it would not hear the case on an expedited schedule and consolidated both California's and Texas's petitions under California v. Texas[55].

The Supreme Court announced earlier this summer that they do not plan to hear the case in October 2020 as previously expected, and will likely hold the hearing after the 2020 elections. The justices will then likely issue their decision in the spring or summer of 2021.

If the Supreme Court decided to overturn the ACA, one of the most important aspects of the law could be overturned or minimized: the pre-existing conditions protections that many patients rely on to access affordable health insurance and receive care. Access to individual market insurance for this population could be severely reduced and would have profound implications. Additionally, the number of uninsured Americans

would rise back to 20 million, and would particularly affect young adults, low-income people, and states that expanded Medicaid.

It is important to note that in the wake of the Supreme Court decision to overturn the ACA, neither Congress nor the current administration has released a detailed plan that could replace the law. After multiple failed attempts to repeal and replace the ACA in 2017, it is possible that some of those proposals could encompass a replacement plan, but specifics have not been released. The Trump administration's stance remains that the entirety of the ACA should be struck down in the Supreme Court case. In June 2020, the Department of Justice released a legal brief restating the administration's position that the law's coverage provisions cannot stand without the defunct individual mandate.

LOOKING AHEAD: WHY PROTECTING THE ACA IS ESSENTIAL

The ACA has provided numerous protections and benefits for Americans over the last decade of the law's existence. Should the ACA be repealed, whether through legal action, or through Congress, the consequences would be dire[56]:

- Up to 23 million people in the U.S. would lose health insurance coverage, raising the nonelderly uninsured rate by more than 7 percent
- Up to 54 million Americans under 65 with preexisting conditions could face higher premiums or lose coverage altogether
- States would lose close to $135 billion in federal funding for their marketplaces, Medicaid, and the Children's Health Insurance Program
- Insurance companies would no longer be required to issue rebates when they overcharge
- Cuts in funding for the Centers for Disease Control and Prevention public health efforts
- Eliminate the requirement that insurance cover preventative services, including vaccines without cost-sharing

While the Supreme Court decision on the legality of the ACA remains undetermined, added to the uncertainty of the COVID-19 pandemic and the rising numbers of Americans signing up for coverage in the ACA marketplace and Medicaid, and the seriously ill patients from both the virus and from delayed care, protecting the ACA and its expansion of health coverage is paramount.

The ACA has significantly improved health coverage and outcomes for millions of Americans and it is crucial to continue to build on the gains the law made in affordable coverage for low and middle-income consumers.

As health care providers, physicians, and clinical researchers discover more about the impact of the virus on their patients, it is highly likely that there will be a need for longer-term care management, and for more specialized or routine care. This will undoubtedly require a health care system that can ensure patients with the certainty of coverage and lower health care costs, which the ACA provides.

Additionally, as America approaches the 2020 elections in the fall, it is clear that health care remains the primary concern of the voters. Support for the ACA has never been so high as it has been in recent polling, proving that protecting this law is not only sensical to ensuring better short- and long-term health outcomes, but is also widely supported by the American people.

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