

What's at Stake in U.S. Health Reform: A Guide to the Affordable Care Act and Value-Based Care

Policy, Politics, & Nursing Practice
0(0) 1–11
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DOI: 10.1177/1527154417720935
journals.sagepub.com/home/ppn



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Abstract

The U.S. presidential election of 2016 accentuated the divided perspectives on the Patient Protection and Affordable Care Act of 2010, commonly known as Obamacare. The perspectives included a pledge from then candidate Donald J. Trump to “repeal and replace on day one”; Republican congressional leaders’ more temperate suggestions in the first weeks of the Trump administration to “repair” the Affordable Care Act (ACA); and President Trump’s February 5, 2017 statement—16 days after inauguration—that a Republican replacement for the ACA may not be ready until late 2017 or 2018. The swirling rhetoric, media attention, and the dizzying rate of U.S. health and payment reforms both within and outside of the ACA makes it difficult for nurses, both United States and globally, to discern which health policy issues are grounded in the ACA and which aspects reflect payer-driven “volume to value” reimbursement changes. Moreover, popular and controversial elements of the ACA—for example, the clause that prohibits insurance carriers to deny coverage to those with preexisting health conditions and the more controversial individual mandate that bears Supreme Court support as a constitutional provision—are paired in ways that might be unclear to those unfamiliar with nuances of insurance rate determination. To support nurses’ capacity to maximize their impact on health policy, this overview distills the 906-page ACA into major themes and describes payment reform legislation and initiatives that are external to the ACA. Understanding the political and societal forces that affect health care policy and delivery is necessary for nurses to effectively lead and advocate for the best interests of their patients.

Keywords

Affordable Care Act, federal policy, health care reform, value-based care, Medicare Access and CHIPS Reauthorization Act

The 2010 enactment of the Patient Protection and Affordable Care Act represents the most substantive U.S. health reform since passage of Medicare legislation in 1965. The 906-page law and accompanying 10,000 pages of regulations (Starr, 2013) can bewilder even the savviest health professionals and health policy experts. The law is rooted in the triple aim of (a) an improved patient experience, (b) enhanced population health, and (c) cost containment (Whittington, Nolan, Lewis, & Torres, 2015). What follows, therefore, is a detailed overview of the Affordable Care Act (ACA), designed to enhance nurses’ understanding of this complex law, and thereby further their civic and professional engagement in the policy process. Payment and delivery reforms that are rooted external to the ACA—for example, Medicare’s value-based initiatives and the bipartisan-supported Medicare Access and CHIPS

Reauthorization Act (MACRA)—are elucidated to aid nurses’ understanding of those reform elements that may be impacted by revision or repeal of the ACA, as differentiated from those that are embedded in non-ACA policies and approaches.

The ACA

The ACA is best understood when divided into three conceptual domains: (a) access to health insurance and

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mechanisms to support coverage;(b) relationships between patients and clinicians, including enhanced transparency; and (c) payment reform models. Although these domains overlap, for clarity they will be examined individually.

Access to Health Insurance and Mechanisms to Support Coverage

Universal health insurance coverage means that all citizens and legal residents of a nation have some sort of protection from the financial impact of the cost of health care they receive. It can be achieved through a number of mechanisms. Employers may be required to provide coverage, termed an employer mandate.¹ Individuals may be required to have health insurance, called an individual mandate. Finally, governmental, tax-funded approaches may be used. Unlike universal coverage approaches that rely largely on a single strategy, for example, Switzerland's individual mandate or Canada's tax-funded approach, the ACA builds on the existing U.S. hybrid model that includes programs such as Medicare and Medicaid that are publicly funded by taxes, commercial insurance offered by employers, and commercial insurance purchased by individuals. These forms of coverage are augmented by household out-of-pocket spending, estimated at 11% of total health care expenditures in 2015 (Centers for Medicare and Medicaid Services [CMS], 2015). This figure excludes complementary health, which accounted for an additional \$30.2 billion in household spending in 2013 (Nahin, Barnes, & Stussman, 2016)

Medicare, enacted in 1965 as Title XVIII of the Social Security Act, is a publicly funded single payer system that covers elderly, disabled, and permanent residents older than the age of 65 years who have paid into Medicare, and since 1972, Medicare includes those younger than 65 years with end state renal disease (Rettig, 1991). Those with amyotrophic lateral sclerosis are eligible for Medicare benefits the month disability benefits begin. Medicaid, also enacted 1965, is Title XIX of the Social Security Act and is a federal program administered by the states. It is subject to state-determined rules and designed to provide insurance coverage to low-income people.

The ACA requires citizens and lawful residents to be covered by health insurance—governmental or commercial—or pay a fee called the individual shared responsibility payment, sometimes called a *penalty* or *fine* (If you don't have health insurance, n.d). Financial subsidies assist those who are required to purchase health insurance but whose income is inadequate to do so.

Essential benefits package as a means to prevent underinsurance and to enable comparisons among plans. One way to make

insurance coverage less expensive is for insurance companies to decrease the services or benefits covered, leaving consumers of such plans unwittingly underinsured. To prevent this, the ACA includes an "essential benefits package" for products sold on the "exchange," a concept that will be discussed shortly. An insurance policy may offer more coverage but must include as a minimum those items deemed to be essential. Some of these services must be offered without cost sharing. In general, these are services deemed to have broad, positive individual, and societal impacts, such as routine immunizations and evidence-based screening and preventive care for infants, children, and adolescents. This policy aspect of the ACA represents an effort to remove financial disincentives that cost sharing may create.

Cost sharing means that those who use health care pay some portion of the tab. Research suggests that individuals who can receive health services with no out-of-pocket cost of any kind use more services. Yet those who use more services do not necessarily have better outcomes (RAND Cooperation, n.d.). The excessive use of health services stimulated when little or no personal financial impact is borne related to the use of such services is termed "moral hazard" (Pauly, 1968). The ACA includes provisions that impose cost sharing for some types of essential benefits, but no cost sharing for services deemed to hold substantial societal benefit.

Cost sharing, actuarial value, and the "metal levels". Cost sharing occurs in three forms: (a) Copayments are small payments made at the time of service that are required of those using health services; (b) deductibles are amounts that must be paid by an individual or family before insurance coverage begins to pay for any subsequent services received, and (c) coinsurance represents a percentage of the cost of care that individuals or families pay after they have paid their deductible. Insurance products organize and stack these cost-sharing arrangements in various ways, which can create confusion for consumers attempting to choose the insurance product that best meets their needs. Thus, the ACA requires insurance products to be organized within defined cost sharing "actuarial value" categories to create the potential to better compare products.

Specifically, the amount of cost sharing or overall out-of-pocket expense (OOP) that is expected to be associated with a particular insurance product is termed actuarial value (AV). An individual or family covered by an insurance product with an AV of 60% would, on average, cover roughly 40% of their health care costs through cost sharing using a combination of copayments, coinsurance, and deductibles. Similarly, individuals covered by an insurance product with an AV of 90% would, on average, pay 10% of their health care costs through cost sharing. The insurance product with the

AV of 60% would have substantially lower monthly premiums than the insurance product with an AV of 90% but greater expense (cost sharing) when services are used.

The ACA limits the amount individual and families purchasing these plans will pay per year, regardless of the AV level or cost-sharing option they select. These maximum OOPs are updated annually and also include OOPs for eligible health savings accounts (HSAs), which are tax-free accounts used in conjunction with high-deductible health insurance policies. HSAs feature prominently in Republican ACA replacement strategies (Appleby, 2017; Jaspén, 2016). The maximum OOP for 2017 is \$7,150 for an individual plan and \$6,550 for a “self only” (individual) HSA (Obamacare Facts, n.d.).

The “Cadillac Tax” on high AV plans. The ACA also includes an excise tax on high AV plans, which reflects an attempt to correct the pretax benefit those with high AV plans currently enjoy, and to discourage inefficient, excessively high-cost plans. Colloquially termed *The Cadillac Tax*, this element of the ACA, originally slated to start in 2018, has been delayed by the U.S. Congress until 2020. This tax, focused on very high-cost employer-based insurance, levies a 40% tax on plans that cost in excess of roughly \$29,000 per year for families and \$10,700 per year for individuals. These are thresholds well above the cost of the plans of most workers and therefore target the most expensive, least cost-effective plans (Furman & Fiedler, 2016). This provision of the ACA has not been popular with employers (Herman, 2016a). If implemented, nurses who enjoy very high AV plans through their employer-based insurance will experience changes to their employer-based benefit packages.

Health insurance marketplaces—the “Exchange”. Under the ACA, the health insurance marketplace, also known as the health insurance exchange, is designed to provide individuals and small business with opportunities to select the combination of monthly premiums and cost-sharing arrangements that best meet their needs. States can establish and operate their own exchange or opt in to the federal exchange.

In 2015, there were five different categories of exchanges, with varying levels of state involvement, risk, and outcomes: (a) state run, (b) state-run using the federal eligibility and enrollment platform, (c) federally facilitated with state plan management and consumer assistance, (d) federally facilitated with state plan management, and (e) federally facilitated (Giovannelli & Lucia, 2015). Rollouts of some exchanges have been protracted and problematic, despite the simplicity of the underlying concept: to provide information as a basis for decision-making when purchasing ACA-mandated insurance coverage. Opportunities for

individuals in state versus federal exchanges were at the heart of the second U.S. Supreme Court Challenge to the ACA, *King et al v. Burwell* (2015). Specifically, language within the law raised this question: Could tax credits legally be paid to individuals in states that did not build their own exchanges but relied on the federal exchange?

Four Virginia petitioners who did not wish to purchase health insurance argued that Virginia’s exchange does not qualify as “an exchange established by the State” as stated in the ACA (Section 36B) and they thus should not receive tax credits. If supported by the Supreme Court, the resulting case law was widely expected to devastate the ACA. Instead, the ACA remained the law of the land following the Court’s 6-3 decision on June 25, 2015. The majority opinion was delivered by Justice John Roberts, as follows:

Petitioners’ plain-meaning arguments are strong, but the Act’s context and structure compel the conclusion that Section 36B allows tax credits for insurance purchases on any Exchange created under the Act. Those credits are necessary for the Federal Exchanges to function like their State Exchange counterparts, and to avoid the type of calamitous result that congress meant to avoid. (Supreme Court of the U.S., 2015, p. 4)

Exchange “metal levels”. The insurance products on all exchanges are set to *metal levels* of *bronze* (AV of 60%); *silver* (AV of 70%); *gold* (AV of 80%); and *platinum* (AV of 90%).² A young, healthy person who is betting on not becoming ill or needing services might choose a bronze plan and therefore pay less each month in insurance premiums, while a person who frequently utilizes health care may choose the more expensive platinum plan and pay less in cost sharing when using services. Not all individuals can afford even the least expensive plan, so the ACA provides subsidies that are benchmarked to the silver plans, that is, individuals must choose a silver plan to receive financial support. Data suggest that this requirement is obscure, or at least not fully utilized as intended. For example, the state of California found that many of those eligible for subsidies (31%) did not choose silver plans and thus did not receive the more affordable version of insurance to which they were entitled (Fung et al., 2017).

Support for individuals, families, and businesses navigating the insurance maze. The U.S. health insurance landscape is convoluted and confusing. The ACA created several new entities to help people make health insurance purchase decisions: *navigators*, *assisters*, and *certified application counselors*. *Navigators* are trained to help individuals and businesses muddle through the maze of options in the health insurance exchange and to

refer individuals to Medicaid or assist them with Medicaid enrollment. *Assisters* can provide these services but also provide outreach and education about the ACA to individuals who traditionally have not had insurance. Arguably, these ACA provisions were well founded, given recent findings that persons most newly insured through ACA initiated mechanisms had been uninsured for a long time (Decker & Lipton, 2017). The ACA also required that each state exchange have a *Certified Application Counselor* program. These three free-of-charge mechanisms join pre-ACA supports, such as insurance brokers, who have traditionally been available for hire to help businesses with health insurance choices. Although nurses certainly can and should be familiar with basic information about insurance options, referral to these trained experts can offer valuable patient support and can aid nurses, especially those who are business owners and are navigating health insurance for themselves and their employees.

Health Insurance Mechanisms in the United States

These new insurance products sold on the exchange since enactment of the ACA have joined long-standing forms of commercial (nongovernmental) insurance. “Self-funded” plans, for example, are typically used by companies that are large enough for their employees to serve as their own insurance risk pool, so they can operate their own health insurance plans. In contrast, in “fully insured” plans the employer contracts with an insurance company, pays premiums to the insurer, and the insurance company pays health claims in accordance with the services predetermined to be covered via the contract. Governmental programs have existed for decades and are a very large payer in the United States. In addition to Medicare and Medicaid, government payers include The Children’s Health Insurance Program, TRICARE (for military personnel and their dependents), The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), and additional care provided by the Department of Veterans Affairs. Taken as a whole, 64.3% of U.S. health care was financed through a governmental mechanism in 2013 and is projected to rise to 67.1% by 2024. Canada—a nation with single payer financing offering universal coverage—is roughly 70% publically funded (Himmelstein & Woolhandler, 2016).

U.S. Supreme Court Rules Enhanced Medicaid Eligibility as Unconstitutional

Medicaid is a federal program administrated by each state and subject to state and federal rules. States receive

federal funds that match those they dedicate to Medicaid, but the matched amount varies depends on the relative wealth or poverty of the state. This creates dramatic differences in the amount and proportion of federal support individual states receive to run their Medicaid programs (Oilove, 2014). States also vary dramatically in their Medicaid “floor”—the income level at which Medicaid coverage begins. To enhance equal access across states, the ACA required that states begin eligibility for Medicaid at no lower than 133% of the Federal Poverty Level. This provision of the ACA did not survive a Supreme Court challenge, based on the issue of state’s rights. Thus, neighboring states may continue to have very different income levels at which their residents become eligible for Medicaid. Nineteen states opted out of Medicaid expansion and states that expanded Medicaid have demonstrated a marked reduction in uninsured hospital stays (Nikpay, Buchmueller, & Levy, 2016).

Relevance of Medicaid and Other Forms of Coverage to Nurses

As with many aspects of the ACA, reducing the number of uninsured hospital stays is of key significance to nurses, both as professionals and as taxpayers, with competing tensions. On one hand, Medicaid represents a substantial portion of many states’ budgets and growing expenses strain availability of funds for other tax-supported services such as higher education or tax relief. Conversely, hospitals remain the largest employer of U.S. nurses, and uninsured hospital days result in charity care or bad debt. Both of these erode a hospital’s financial capacity and sap the availability of funds for salary and benefits, adequate staffing, infrastructure development, and facility upgrades.

Bad debt differs from charity care, which comes into play when a person seeks services but does not have any form of insurance coverage. Typically, in that case non-profit health care organizations first attempt to identify a form of coverage for which the patient may be eligible. Bad debt, on the other hand, is not known prior to provision of services but rather represents the unpaid proportion of care already received for which the individual is responsible, for example, the cost share. It was widely anticipated that the passage of the ACA would result in a reduction in charity care because all are required to have coverage of some form or pay a fine. But it was also anticipated that ACA could bring an increase in bad debt. This perspective assumed that individuals and families that would opt for less expensive, lower AV plans with higher cost sharing might then be unable to fully pay the proportion for which they are responsible.

Hospitals, in determining their budgets, project an expected amount of charity care and bad debt.

Paradoxically, charity care offers some financial value to a hospital because it can also be regarded as part of the hospital's required "community benefit" that is necessary to retain "nonprofit" status and maintain exemption from taxes. Roughly 60% of U.S. hospitals are nonprofits; the remainder is divided among public government-owned hospitals and for-profit hospitals, according to the American Hospital Association (2016.) The financial impact of this preferred tax status was \$24.6 billion in 2011 (Rosenbaum, Kindig, Bao, Byrnes, & O'Laughlin, 2015).

Public controversy over the actual value of the benefit a hospital brings to a community relative to the loss of tax revenue led to congressional consideration of this issue. Thus, the ACA included new internal revenue service requirements that hospitals must meet if they are to retain nonprofit status. These include requirements for hospitals to conduct community needs assessments every 3 years and develop corollary implementation plans to address identified needs. Hospitals are also required to have written policies on financial assistance for the needy and limitations on hospital charges for those eligible for financial assistance (James, 2016).³

Additional Mechanisms to Support Access to Health Insurance

Health insurance is a mechanism that spreads the financial risk for cost of care across a pool of people. An insurance pool consists of all the policyholders; the largest insurance premium cost driver is the volume of services used multiplied by the cost of those services. In other words, the "healthy carry the sick" financially. One way to offer less expensive health insurance is to exclude individuals with a history of illness from entering the insurance pool. Prior to the ACA, an individual could be denied health insurance on the basis of a preexisting condition, an illness or disorder that was acquired before health insurance was sought. Under the ACA, no one can be denied health insurance on the basis of a preexisting condition. Similarly, prior to the ACA, individuals and families were subject to "lifetime caps." Under these caps, once the threshold of a certain dollar amount was reached, the insurance company no longer reimbursed the cost of additional services. Both of these situations precluded access to health care for those most likely to need insurance due to illness, chronic condition, or injury. A third way the ACA modified insurance plan requirements is to allow children to remain on their parent's health insurance policy until age 26 years, even if a child is no longer a dependent or is married. Evidence suggests that this strategy has not only enhanced young adults' access to all forms of health care but also provided treatment to

those with possible mental health disorders (Saloner & Le Cook, 2014).

Community versus individual rating. In general, older people are more expensive to insure than young people, and young women are more expensive than young men, mostly because pregnancy can be costly. The ACA limited the age differential to no more than 3:1, meaning the most expensive plan can be no more than three times the least expensive plan. This enhanced access to affordable coverage for aging Americans, who are often likely to have greater needs for services than others. The ACA also removed gender as a rating factor, which enables more young women to have access to affordable health insurance. These requirements also result in comparatively higher cost premiums for nonelderly individuals and men, respectively.

Political Controversy and Interacting Forces in the U.S. Health Insurance Market

Much of the ACA political swirl in the beginning of 2017 under the Trump presidency and the Republican controlled U.S. Congress relates to insurance market reform, with particular rancor from conservatives regarding the individual mandate. This opposition is in marked contrast to the original conservative support for the mandate as a viable option to preclude a single payer approach to coverage (Cooper, 2012; Roy, 2012). On the other hand, to permit young adults to remain on their parent's health insurance is popular, as is elimination of the preexisting condition exclusion clause and lifetime caps. A total repeal of the ACA would remove these three well-received provisions.

Notably, while expanding access to health insurance, these provisions do not make health insurance more affordable because, in general, they add high utilizers to the insurance pool. Yet, for insurance companies to be financially viable when required to offer health insurance to those who are ill or have chronic conditions, there needs to be enough "well," low-utilizing individuals paying premiums to offset the costs created by those who are ill or using services. Thus, without the individual mandate, there is concern that the healthy will opt out of coverage as high utilizers opt in (termed *adverse selection*). This would lead to higher costs for those who remain insured and a potential collapse of the individual insurance market. One potential strategy supported by key Republicans is state-level "high risk pools" to remove the most ill from plans and thereby lowering cost for others. Instead these high utilizers would aggregate in their own risk pool. Some U.S. states, for example, House Speaker Paul Ryan's state of Wisconsin, are held up as examples of successful state-level high-risk pools. Yet, critics note that the 35 high-risk pools that

existed before the ACA were expensive and unsuccessful in providing access to high quality, affordable insurance coverage (Meyer, 2017a).

Other factors forged higher prices for exchange products than anticipated when the ACA was enacted in 2010. For example, those who purchased health insurance through the exchanges were, in aggregate, more ill than originally projected and thus generated higher costs. This can impact the financial solvency of a company, a factor compounded by the insurance industry's early strategy of underpricing products on the exchange to attract buyers to their product (Herman, 2016b). In response, some insurance plans have left the exchange marketplace, a factor some cite as evidence that "Obamacare" is failing. Others, however, note that companies and products that have exited the exchange marketplace differ from those who remain and conclude that such "market entry and exit are consistent with natural competitive processes separating out firms that are best suited to adapt to a new market" (Garthwaite & Graves, 2017, p. 4). These competing forces illustrate dynamic political tensions, as market competition is generally viewed positively by U.S. conservatives and Republicans who at the same time do not support some or all of the ACA.

ACA Supports to Stabilize the Insurance Market

In the early years of the ACA, three provisions supported insurance companies' entry to the exchange marketplace despite uncertainty regarding the health or illness status of those who might purchase those plans. The three provisions are as follows: risk corridors, reinsurance, and risk adjustment, collectively termed *The Three Rs* (Bertko, 2016; see Table 1). Reinsurance and risk corridors were conceived as temporary measures needed only in the initial rollout of the ACA. They expired in 2016, leaving insurance companies in the exchange without a full complement of stabilizers to offset financial loss. These strategies are currently being aired in the U.S. policy debate about stabilizing the individual insurance market.

ACA Provisions on Relationships Between Patients and Providers and on Transparency

Shared decision-making. Noted as a "sleeper provision" of the ACA (Lee & Emanuel, 2013, p. 6), the law includes support for "shared decision making" between provider and patients. Using decision aids and other approaches, shared decision-making enables prospective patients to be more clearly informed about their options for care—be they treatments and interventions or watchful waiting—and the benefits and risks these different approaches offer. The goal is to align care with a

patient's values in order to improve health outcomes and reduce costs and unexplainable variations in approaches to care.

Transparency. The ACA has provisions that address the health care system's lack of transparency on cost of care, and on payments given to physicians or teaching hospitals by makers of drugs or devices. Section 6002 of the ACA, also known as the Physician Payment Sunshine Act, requires that any payments or transfer of value to physicians or teaching hospitals be reported. Once reported, these payments are listed by name of physician or hospital in a publicly available searchable database. This section of the ACA also requires disclosure of ownership or investments by physicians in certain health-related manufacturers or group purchasing organizations (Richardson, 2014).

Early findings suggest that this ACA provision has been on target. An analysis by ProPublica, an independent, non-profit newsroom, for example, found that physicians' prescribing behavior is likely to be affected by payments from drug and device makers, because physicians who have received funds from drug companies prescribe a higher proportion of brand name drugs than their peers even when a much cheaper generic drug is available (Ornstein, Grochowski Jones, & Tigas, 2016). Optimally, the publicly accessible website that documents who receives funds and how much they receive will create the "sunshine" transparency that modifies behavior.

Other ACA provisions that address transparency are focused on the health insurance industry, including a requirement that policies provide a uniform summary of benefits in plain language—what is covered, and what are the limits, exclusions, and cost sharing. Language in the ACA also addresses quality, with an aim of quantifiable performance, care management, and financial incentives for quality. Examples include the Centers for Medicare and Medicaid Services Five-Star Quality Rating System for Medicare Advantage Plans (Sennett, 2010). Medicare Advantage plans are Medicare plans sold by commercial insurance companies. In 2016, 31% of those covered by Medicare were enrolled in Medicare Advantage plans (Kaiser Family Foundation, 2016). The health insurance exchange can also be viewed as an effort toward greater transparency concerning the cost and cost sharing that different insurance plans provide.

What Is Next for U.S. Health Care Policy?

The future of the ACA is uncertain. What is certain is ongoing implementation of payment models directed toward value. The ACA included funding to spur testing of innovative models of payment and delivery reform

Table 1. The Three Rs: Reinsurance, Risk Corridors, and Risk Adjustment, Adapted From Berko (2016).

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1. **Reinsurance** limits the amount of loss an insurance company will assume when insuring new enrollees. Funds are gathered from all commercial insurance—both individual and employer based—on the basis of the number of lives insured. These funds are distributed to the new market for individuals when there is higher health risk and unexpected pent-up demand for services, both of which generate high costs that the insurance company must assume. It was anticipated that reinsurance would be needed only in the first few years of the ACA because trend data would be available to insurance companies after that and would enable them to set adequate rates for their enrollees.
 2. **Risk corridors**, modeled after the successful approach used during the first years of the Medicare Part D program (pharmaceutical coverage passed and developed during Republican George W. Bush's administration), use U.S. Treasury funds to reimburse insurers whose claims reach more than three percent above the expected target. This provision has been troubled; Congress changed the risk corridors rule and the U.S. Treasury did not have sufficient funds to reimburse insurance companies for these losses.
 3. **Risk adjustment** redistributes financial resources from insurance companies who enroll lower cost, healthier people to insurance companies that enroll individuals who are more at risk, and thus incur higher costs. This element potentially provides an incentive to insurance companies to enroll more ill individuals and runs counter to the typical adverse selection scenario in which insurance companies seek to attract the young, healthy, infrequent consumers of health care services. At the same time, such shifting funds create unpredictability for some insurers, which potentially makes participation in the exchange less desirable.
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through creation of the Center for Medicare and Medicaid Innovation and through federal grants that include state innovation model funding (Van Vleet & Paradise, 2014). Some of these tested approaches are now being adopted by private payers.

Payment models include those in which providers take responsibility for patient outcomes as measured by defined metrics, for example, services delivered by patient-centered medical homes, and also models in which providers accept accountability for patient outcomes and cost of care. This can be done, for example, through bundled payments and risk bearing accountable care organizations. The term “risk bearing” means that the providers bear the financial impact of their clinical decisions, in terms of both profit and loss. In January 2015, the Department of Health and Human Services clearly defined the path ahead as one that will shift to payments that are no longer fee-for-service. The goals are to replace 50% of traditional fees-for-service with value-based approaches such as accountable care organizations or bundled payments by the end of 2018, and with 90% of reimbursement tied to quality and value. This is a dramatic change, given that 95% of physician office visits were fee-for-service in 2013 (Zuvekas & Cohen, 2016).

On April 16, 2015, Congress signaled additional support for a move to value-based care when it passed the MACRA and merit-based incentive payments with overwhelming bipartisan support, including an affirmative vote from President Trump's Secretary of the Department of Health and Human Services, Tom Price, who was then a Republican representative from the U.S. state of Georgia. Beginning with measurement in January 2017 and payment adjustments in 2019, physicians, nurse practitioners, physician assistants, certified nurse anesthetists, and clinical nurse specialists seeking reimbursement from Medicare will be in either an advanced alternative payment model such as a qualified

accountable care organization and will receive a 5% bonus increase in reimbursement; or they will be subject to the merit incentive payment system. Under the merit incentive payment system, automatic fee-for-service reimbursement increases are limited to 0.5% until 2020, at which point they drop to zero, with any reimbursement increases subject to determination by a composite score on quality, resource use, clinical improvement, and meaningful electronic health record use criteria.

As a result of industry pushback at the speed and complexity of implementation, providers remain subject to MACRA rules, but can choose their 2017 level of involvement. Nonparticipation creates a downward 4% adjustment; minimum data submission enables the provider to avoid a downward adjustment; 90 days of 2017 data bring a neutral or small positive payment adjustment; and full year of 2017 data create the potential for moderate positive payment adjustment (Centers for Medicare and Medicaid Services Fact Sheet, n.d.).

Although the fate of payment reform is uncertain in the Trump era, many policymakers and health policy analysts anticipate an ongoing transition to value-based care because of private sector momentum in this direction (Wilensky, cited in Zamosky, 2017). Former Republican Governor Michael Leavitt of Utah further noted both parties can agree that fee-for-service needs to transition to value-based payment and that coordinated care is better than uncoordinated care, but these shifts need to occur without imposing further budget burdens or deficits (Zamosky, 2017 webinar). Finally, state sponsored reforms will continue under a Republican administration, even if the state initiatives are more progressive than conservative leaders prefer, this being consistent with the strong support for state's rights among conservatives.

Taken as a whole, payment reform will continue to dramatically redesign the U.S. health care landscape.

Essential nursing skills in this era include care coordination and care redesign, management and use of data as a tool to guide action, skill across the care continuum, and an appreciation of the underlying financial and quality metrics that create the revenue needed to deliver care. Nurses should also seize the opportunity uncertainty creates to influence health reform by carefully monitoring the ongoing policy dialogues and respond with reasoned action at state and national levels.

Addendum, June 2017

Since the submission of this manuscript, the House of Representatives narrowly passed the American Health Care Act (ACHA) in May, 2017 and in June, 2017 the Senate GOP leadership introduced the Better Care Reconciliation Act (BCRA). There are similarities and differences between the ACHA and the BCRA. Both retain the popular ACA provision that allows children to stay on their parents' health insurance, shift allowable insurance age rating band from the 1:3 required in the ACA to 1:5 (with the option for states to set their own band ratings), support the establishment of state high-risk pools, and have an array of provisions that decrease funding for Planned Parenthood clinics and abortion. The BCRA repeals the ACA mandates and cost-sharing subsidies; the AHCA repeals these and also repeals ACA standards for AVs and premium subsidies, approaches expected to increase out-of-pocket costs. Both the BCRA and AHCA encourage the use of HSAs, allow states to seek waivers from the essential health benefits requirements, and propose dramatic changes to Medicaid, with a per capita cap based on 2016 spending starting in 2020. This approach will result in a marked reduction in federal support for Medicaid and less federal oversight regarding how states spend Medicaid dollars.

Although states may contribute additional resources to Medicaid, most states are struggling to meet even current levels of spending. No longer an entitlement program, Medicaid caps will likely mean a reduction in services, beneficiaries, or both. The BCRA offers more dramatic changes to Medicaid than the ACHA, but at a slower pace. Both also allow states to set work requirements for Medicaid recipients who are not disabled, pregnant, or elderly. The overall reduction in federal support for health care and other proposed changes would enable a dramatic reduction in taxes and disproportionately benefit high-income earners. A full explication of the ACHA and BCRA is beyond the scope of the manuscript. An excellent resource that expands on the description of the ACA in this article and compares provisions among the ACA, ACHA, and BCRA can be found at the Kaiser Family Foundation website <http://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/>.

Politics to Consider

Lawmakers can come to different conclusions about the viability and reasonableness of the same proposal. Not only are there marked differences between the Democrats and the Republicans and between the House and the Senate, the Senate Republicans do not represent a homogenous policy block. Two Republican senators, Susan Collins (Maine) and Lisa Murkowski (Alaska), oppose defunding Planned Parenthood. Seven Republican senators (Tom Cotton, Arkansas; Jeff Flake, Arizona; Cory Gartner, Colorado; Bill Cassidy, Louisiana; Dean Heller, Nevada; Rob Portman, Ohio; and Shelley Moore Capito, West Virginia) have voiced support for protection of Medicaid expansion and coverage for addiction care and management. Three Republican senators (Lamar Alexander, Tennessee (who also is chair of the Senate Committee on Health, Education, Labor, and Pensions); Bob Corker, Tennessee; and John Thune, South Dakota) lead the "compromise caucus," which seeks a way to reach consensus and pass a bill. Senators Ted Cruz (Texas), Rand Paul (Kentucky), and Mike Lee (Utah) lead the "deregulation caucus," whose members want to repeal most or all of the ACA taxes, insurance market regulations, and subsidies.

Democrats uniformly oppose repeal of the ACA, generally instead preferring "repair" to address ACA shortcomings. Four Democratic senators, for example, have introduced a bill to make reinsurance, one of the previously discussed "Rs," a permanent part of the ACA as a strategy to support the viability of the individual insurance market (Lee, 2017). Others, notably Senator Bernie Sanders (Vermont), prefer a publicly funded single payer "Medicare for all." Reform is also proposed on the state level, with two states—New York and California—considering single payer financing despite two 2016 aborted state-level attempts: Colorado's 4:1 voter defeat of a single payer and Vermont's 2016 transition from a single payer to an all payer, total cost of care model (Backus, Gobeille, Hogan, Holmes, & Rambur, 2016).

Moreover, forecasts of federal budget impacts of the different proposals and of the number of people who will lose coverage are important political considerations. The bipartisan Congressional Budget Office, for example, projects that, if the House version of AHCA becomes law, the number of insured would increase by 14 million in 2018—growing to 23 million by 2026 (Meyer, 2017b). In contrast, actuaries for the CMS project numbers that are roughly 10 million fewer. Although the CMS actuary report may seem like good news for the House of Representatives plan, CMS also estimates that by 2026, average cost sharing would be 61% higher than under current law, and net premiums would actually be higher than under current law by about 5% (Meyer, 2017c).

At the time this article goes to press (June 23, 2017), the potential for consensus between the House and Senate is unclear, and the ACA remains the law of the land.

Policy and Political Strategies for Nurses

This is a time for nurses, regardless of political persuasion, to study health care reform issues, follow their developments, and interact with members of their congressional delegation. The roughly three million nurses in the nation represent a powerful, influential body, and thoughtful analysis of the issues brought to members of Congress by nurses could be important in explaining the impact of the federal laws and proposals on patients and quality of care. Nursing organizations such as American Nurses Association, National League for Nursing, American Association of Colleges of Nursing, American Academy of Nurse Practitioners, and specialty organizations have detailed information on their websites and also political action strategies that are designed for easy participation. Consumer organizations representing patients and populations of interest—American Diabetes Association, AARP, and The American Civil Liberties Union, for example—offer perspectives relevant to their mission that illustrate yet other useful views. An excellent resource for learning about elected officials, how to contact them, and how to register to vote is the League of Women Voters (lwv.org). Now is the time for active engagement: discuss the issues with colleagues, form study groups, invite speakers. Most of all, do not let the complexities of health care reform inhibit your active engagement in this compelling social, economic, health, and distributive justice issue facing our families, our patients, and our nation.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

Notes

1. Small businesses (less than 50 employees) are excluded from the ACA employer mandate and therefore are not required to offer health insurance. Further, businesses with 50 or more employees are not required to offer health insurance to “part time” employees, that is, those who, on average, work less than 30 hours/week or 130 hours/month.
2. Products that fall outside their designated AV value have to readjust the cost sharing to stay within the range. In this manner, people can be assured that they are actually receiving the metal level they chose, but if there is drift outside the

range it may also mean a change to their insurance rates and cost-share arrangement mid-enrollment period.

3. In the United States, payers and insurance groups pay varying amounts for the same services, and insurance companies negotiate with health care delivery systems for lower cost care in order to offer the lowest cost insurance possible. As a result, the most financial needy could have been charged the highest price for services because they are not part of a group negotiation for the lowest prices. Although some hospitals voluntarily offered the financially needy a lower charge, the ACA required changes to the IRS code to determine specified limits on hospital charges for those eligible for financial assistance.

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