Implementing the ACA
Challenges & Implications

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Thank you very much for the invitation to speak here today. I am very honored to be asked to open the Davis Lecture series for this year with its focus on Implementing the ACA. I am particularly honored because I am not an academic--most of the people who will speak to you in this series are. But I'm a guy who implements things. And I am delighted to be able to share with you some of the things that make implementation both challenging and important.

At the risk of spoiling the punch-line, I'll preview my comments by quoting my boss Julie Hamos. For many years she was a legislator and then she came to run the Department of Healthcare and Family Services. About six months after she started, she ended a particularly difficult meeting muttering in frustration: "It's sure a lot harder to implement these laws than it is to pass them."

But how things get implemented is what really makes a difference. That is where rubber meets the road. It is probably more important that we study how that happens than what the supposed policy says.

In that vein, before I get into the body of my remarks, I want to give a shout out to all my fellow ACA implementers--the thousands and thousands of people who have been busting their butts to get this law up and running. And while there are glitches on every front, I think it is hard for the uninvolved to understand how many hours of blood, sweat and tears have gone into turning this law into reality--from the top management at HHS all the way down to the 60 caseworkers in Illinois who have been working nights and weekends to test our new eligibility system. These are not the "government workers" of the popular imagination. These are talented and dedicated people and I have been honored to work along with them. Hats off!

At the core of today's comments are three points:

1. The ACA is very good thing
2. But it is a bear to implement
3. And this has profound consequences for how we evaluate it

The ACA Is a Good Thing

This is probably a sympathetic crowd to the idea that the ACA is a good thing. But, as we kick off this particular series of lectures, I think it's worth pausing for a moment to note that in all the political controversy, public bickering and implementation problems--this is a big...deal. Because of the Supreme Court ruling allowing states to not implement the Medicaid expansion, there will still be large holes in the safety net, but no single step in American history has brought health care coverage to so many people in a single stroke. It is a powerful step to the verge of universal coverage for our citizens.

Don't get me wrong. There are huge problems with this particular approach. I'll spend most of my time talking today about some of those problems. And I don't think health care coverage is the be-all and end-all of public policy. If I were emperor, I am not even sure it's the policy issue on which I would focus most attention. Especially here in America where there are more fundamental issues and the health care system is particularly wasteful to begin with.

But that being said, judging from the loud indignation of the opposition, one might think there was some other really compelling idea that was not selected and people are still complaining about that. That is not the argument we are hearing. The raging, noisy discussion has been Obamacare or status quo--which means 15 to 20% of the population would be left without insurance. Siding with the status quo is saying "Forget the evidence that health insurance coverage has real health implications for people because it is more important to maintain our relative privilege."

Somehow, in the media and the popular thought process, the bones of that argument have been lost in the fog of covering the argument itself without insufficient consideration of what the argument is about.

So I want to start with a reiteration of what should be obvious: this is about the implementation of a law to get healthcare coverage to millions of Americans. An overdue law, I might add. Nevertheless...

Obamacare Is Hard to Implement

I am going to roughly divide the concerns into two, somewhat overlapping categories--contextual and substantive

While the rancorous, partisan nature of today's America is obviously an important contextual feature, I don't need to dwell on that. Rather, I want to start this part of the discussion about an even more fundamental problem that is so big we hardly ever take it into account in our discussion of specific public policies. To wit: America has an absurdly difficult system of government in comparison with the rest of the world. I want to start by addressing how this system of government promotes an impossible set of challenges to crafting implementable laws.

The degree of separation in the government--among the legislative, the executive and the judicial--leads to writing laws in America that are far more detailed and more specific than laws in the rest of the world. Congress is determined to push the executive to do this specific thing or that, and the courts are prepared to serve as umpires to determine whether it did or not. But each one of these branches in politicized and often pursing its own agenda. Specificity begets specificity and Congress pushes for ever more specificity in the laws. This is problematic because no matter how hard they try, legislators are unable to write enough details to fully foresee how things will play out when implementation starts. (Over the last couple years, one of my mantras has been a wonderful quote from the boxer Joe Louis--"Everybody has a plan... till they get hit!")

Moreover, all these laws--which are over-specified on the basis of any international comparison--are on top of other equally specific laws. The result is an accretion of details that is in reality too complex to be properly accounted for in the hurly-burly of legislative process. Thus it happens that an enormously complicated ACA law is layered on top of, for instance, 45 years of accumulated legal details about Medicaid, insurance and tax codes.

It may be obvious, but is worth making explicit that a side-consequence of too many, too specific laws is that within the executive branch, power is spread over a tangle of federal bureaucracies, many of which have little practice of talking to each other, or even common vocabularies. In order to implement the ACA, Revenue, HHS, Labor and several other departments not only had to create entirely new structures, they also had to line up their historic structures and laws to come up uniform interpretations that took into account the entire maze of history that each of them faced individually. I'm not close enough to the Federal level to know how many of the delays in getting out information necessary for implementation was due to inter-departmental coordination issues. I would speculate it was material.

This structure of American government is an ongong temptation for both the legislative and the executive branch to expand their powers in the war against each other. This has very significant implementation consequences stemming from the procedural requirements legislatures at both the federal and state level have inserted into core business processes, such as budgeting, procurement and personnel. (One of the major delays in getting the Federal Marketplace running was a procedural spat over hiring the vendor to implement the core computer system. These delays continue to ripple throughout the system.) Thus we get both too much separation of power and too little all at the same time.

America is also an outlier in the way it structures its judicial review of legislation. In no other developed country would it take more than two years for a constitutional challenge to a major law like the ACA to make its way to a decision. The chilling effect of this delayed judicial process on implementation is enormous. (I cannot tell you how many times I heard Illinois legislators say "We shouldn't take up this bill on establishing an Illinois marketplace until the Supreme Court decides." My Marketplace colleagues are being punished on a daily basis with the consequences of those decisions postponed.)

Which points to another important issue: this challenging federal structure is mirrored in 50 states, many of which are in open warfare with whatever federal policy there is. The ACA was written to go across not only 45 years of national Medicaid legislation, but on top of 45 years of separate states legislation also written at an equal level of detail. And states, which have had the historic responsibility for regulating insurance, each have their own insurance legal structure. If laws at the federal level are an unkempt garden, the legal structures in many states are nothing short of an overgrown jungle.

And, again, I'm talking only about the challenges of the legal infrastructures, without mentioning the inherent difficulty of farming out so many crucial decisions and administrative structures to so many individual state entities, each in some significant sense an independent nation.

On top of these inherent problems, there are three other important contextual considerations:

- Even within the context of a strange governmental/legal structure, the ACA was an aberrantly bad law because it did not follow the usual legislative process. Due to the depth of the partisan divide in Congress, the promiscuous application of filibusters, and the failure of the Democrats to hold on to Kennedy's Senate Seat in Massachusetts--the law never had a conference committee that would have ironed out at least some of the peculiarities in the law.
- Usually with a bill this complicated once implementation is started and the inevitable set of problems starts to come to light, it is possible to run a "clean-up" bill to address obvious issues. However, the toxic environment in Congress precluded anyone even thinking about clean-up legislation. Obvious issues--issues on which there was clear agreement about the problem and the fix--remained problematic.
- Related to the toxicity of the atmosphere, the executive branch took the position that it had to follow the law scrupulously. While particularly in the last six months there have been a few "winks and nods"--some of which will surely wind up in court and could lead to disruptive decisions several years from now--for the most part the Feds have taken the attitude that silly or not, that's the law.

So, not surprisingly, this structural context leads to a host of substantive implementation problems. I will not attempt a comprehensive list. But I want to outline some broad categories of problems and give a few specific examples to give the flavor of the issues.

1. Timing

The first substantive problem I want to talk about is the timing. Two years ago, Paul Starr was here at U of C and one of the central points of his discussion was that it was a strategic mistake to postpone the implementation till 2014. From a political and academic perspective, he may have been right. But from an implementation standpoint, that is ludicrous. In the world I actually inhabit, the legislative schedule was simply not ***enough*** time to do this right.

Bottom line is there were too many moving parts. In Illinois **Medicaid**, the time line we followed was almost as tight as it could have been. We had a few missteps, but very few. We were able to do this because we had a supportive Governor. We started running at full speed right away, breathed a sigh of relief when Quinn was re-elected in 2010, but never slowed down. When the Supreme Court ruled that Medicaid expansion was not automatic, we kept going hard on the bet that the Democratic legislature would approve in the end. They did wait till the last moment, and was part of another strange piece of legislation, but it happened.

To understand the specific Medicaid implementation challenge of the ACA, one must understand that adding people to Medicaid is the least of the problems. The real challenge is accommodating the new eligibility standards.

Practically speaking, it would not be possible to implement the ACA vision of a seamless connection between Medicaid and the Marketplace without some uniform standard of eligibility, something that would achieve consistency between standards across the two. The overall concepts of the ACA required that be related to income tax, because the entire operation of the Marketplace depended on its coordination with the tax system. Hence the idea of defining eligibility based on the concept known as Modified Adjusted Gross Income, or MAGI as it is typically known. MAGI income is a derivation of a line 36, adjusted gross income, on the income tax return. As important as is the income definition itself, the interpretation of MAGI also requires a consistent construction of the family across states, something that sounds straightforward until one gets into the implementation details. (The ACA also created an apparently uniform standard for Medicaid programs across states, at 138 percent of the Federal Poverty Level. As implemented, while tremendously increasing consistency among states, the requirement of maintenance of effort for children's Medicaid continued fairly wide variations in some segments of the Medicaid population. In any event, from an implementation standpoint, the actual income standard itself is a trivial detail. *How* it is calculated is what makes the difference.)

Thus, while not widely appreciated outside Medicaid circles, the mandate to use MAGI principles for eligibility determination is at the heart of the Medicaid implementation of the ACA. This requirement forced literally every state in the country to adopt not simply new eligibility standards, but an entirely new eligibility process. In Illinois, for instance, there was absolutely no way this could have been accomplished without a new eligibility system because the old system had evolved in 35 years of hard-coded adaptations around the existing principles. Reeling that back in and reloading was out of the question.

But even with consistency of purpose, in Illinois we were hamstrung by a legislatively-mandated procurement process that is ponderous beyond belief. To execute a contract in Illinois requires 52 separate approvals--not including several sets of approvals by the Federal government. HHS has been very liberal in finding new sources of money for eligibility systems. Money has been plentiful. But time has been the scarce resource.

We signed our contract with Deloitte, who is installing our ACA compliant system, on October 16, 2012--two years from when we had started the process and less than one year from when it needed to be operational. We sort of made it, but we had to make all kinds of compromises to turn this system on October 1. Were it not for the hard date--less the legal implications and more the political issues--there is no way we would have flipped the switch last week.

As something of an aside, I would note that even while recognizing the severity of this issue, I have frequently told colleagues both in Illinois and in other states: "Thank god for that deadline." In this era, government's largest output is often dithering. So, while I am not completely comfortable with the October 1 launch date, I also fully recognize that without that fixed endpoint, we would still be mired in some procurement nightmare, laboring along with our 35-year COBOL based system. Still, another couple of weeks would have been appreciated.

The issues on the **Marketplace** are slightly different. The ACA specified that the Marketplaces would be state-run, unless the states declined to run their own exchange, a provision insisted on by Republicans. In the end, only 17 states decided to run their own exchanges--mostly Democratic states. The uncertainty of whether a state would run its own marketplace or let the Feds run was itself a problem, both for the states trying to prepare and for the Feds who were never quite sure what they were preparing for. Illinois was not atypical. Two intervening elections, the momentum-chilling run up to the Supreme Court, and the general reluctance of the Republican party to enter into serious dialogue about the process, and it was not clear until the spring of 2012 that Illinois would not have its own Marketplace. Implementation started, sputtered and stopped during this period.

However, it also seems to me that many of the implementation issues around the marketplace in Federally run states were due to the inability of the Federal government to get all the pieces lined up in time. For instance, earlier decisions about availability of marketing money would have made a great deal of difference in Illinois, as would much clearer directions on the establishment of an Illinois specific call center. Confusion and delays around the process of getting various kinds of assisters in the field is a Federal problem, and unfortunate. To be fair, some of this was caused by the political environment that created reluctance to push certain key decisions past the 2012 presidential election. But even for good political reasons, the impact on the ground was trouble.

2. Insurance Fragmentation

Many of things that are challenging about the ACA are a consequence of its specific commitment to building on the existing structures of health insurance coverage in America. I am not going to comment on whether or not that is good policy, but I will remind all that was the only realistic political option. Although implementation may be harder than passing laws, there are no implementation challenges unless you actually pass the law.

Building on the existing system is hard; if for no other reason than our existing system is distinguished among healthcare systems internationally for the high degree of fragmentation. The implementation process is rife with such problems, but let me offer an example that illustrates the problem. This example is a little extreme, but it is not preposterous and it shows a lot of the issues in this one example.

Imagine a household of five--Ken, Maria and three kids.

- Ken and Maria are not married, but have one child together.
- The household also contains one child from each of Ken's and Maria's previous marriages.
- Maria makes $34,000 per year and files a tax return
- She claims all three children as dependents
- Ken makes about $18,000 per year, but it's mostly in the spot labor market so he doesn't file a tax return

I think most of you have experience with lower income families will agree that while not typical, there are a fair number of households with more or less similar circumstances.

Given these facts, the resulting insurance coverage for this household under the ACA would be:

- Maria would get her coverage from the Marketplace
- Ken and his child from the previous marriage would be on traditional Medicaid
- Maria's child would get coverage from Medicaid, but would incur higher copayments than Ken's child incurs
- Ken and Maria's child would be covered by All Kids, a form of Medicaid, but would require premiums and still higher copays

I would also note that if Maria were pregnant, who Maria claimed as a dependent, Ken were undocumented, one of the kids were over 18 or anyone in the family were disabled it could change some of the decisions.

Setting aside the difficulty these various coverage options might make for the family, from an implementation standpoint this creates a number of issues, for both Medicaid and the Marketplace.

For Medicaid, just programming the computer is very hard. (The Illinois system requires north of 8000 distinct rules to determine Medicaid eligibility. Each one of those has to be written, tested, retested and at each step the results must synchronize with the rest of the program.)

Computer programming is just the start. Administrative rules must be written and adopted, operational policies must be developed, caseworkers trained (about 3000 in Illinois), advocates and assisters educated on these nuances, providers need to take account of these nuances in their billing and operations, materials created to try to explain to the families, and appeal

processes developed. And by the way, every state has to go through the same exercise. And there is also the situation that just a few miles from where we sit, this same family could experience somewhat different outcomes depending on which side of Indianapolis Blvd they live.

Moreover, for each of the 34 states that have not yet established their own marketplace, all this has to be coordinated with the Federal Marketplace. It needs to determine whether any applicant is Medicaid eligible before it determines whether the applicant is eligible for a subsidy on the Marketplace. Even with some degree of uniformity from the adoption of MAGI principles, it is impossible for the Marketplace to accommodate by itself the level of complexity discussed above for each of the 34 states simultaneously. It is even less plausible to expect consumers to be able to puzzle their way through this maze prospectively, so a process had to be devised to transfer cases between Medicaid and the Marketplace for applications believed to ineligible for the first place they were filed. This is an enormous implementation challenge that would not be necessary were there not the commitment to preserve the distinction between Medicaid and private insurance on the Marketplace.

I really don't know how this is working nationwide. It will be longer before I have any sense of it. In Illinois, we have been able to work out a process to make these transfers, but it is pretty creaky and it's definitely not going to work at all until November, which could create some real start-up issues depending on the number of early applicants. And Illinois is a state actively cooperating with the Federal Marketplace. I can only guess how this is going in states that are not being at all cooperative. (In some ways it will be easier in states that are not expanding Medicaid because the gap between Medicaid and the Marketplace could be so large, applicants will be much more likely to know what benefits they are eligible for. Of course, many of them will be eligible for nothing.)

As a side note, Illinois has adopted a number of strategies specifically designed to mitigate these issues by

- Taking aggressive steps to help people apply first to the place, Medicaid or the Marketplace, where they are more likely to be eligible.
- Moving to get as many people as possible who are Medicaid eligible enrolled before they had the chance to apply to the "wrong" place.

There is another huge fragmentation issue that has proven difficult for the Marketplaces, state or federal. That is how to coordinate with employer sponsored insurance. Again, because there was an explicit goal to preserve as much as possible of the existing health insurance superstructure, the ACA had very specific requirement to preserve employer sponsored insurance responsibilities.

These have proved more or less impossible to implement as imagined. There is no practical way, particularly in the allotted time, to build a system that could effectively sort the details of family situations and employer insurance and present that information to a Marketplace in a

way that it could use it to drive decisions. Not only is there no national data base or uniform set of descriptors on what health insurance is provided, but sorting out how that related to the individuals in each household quickly becomes mind-bogglingly complicated.

How much the goal of preserving employer sponsored insurance is attainable will remain unclear for some time. While some stories of employers reducing hours to avoid paying fines have received considerable press, those are primarily in places where the employees were not currently receiving health insurance. Whether or not there will be an epidemic of employers actually ending health insurance is yet to be determined.

But it *has been determined* that it is very difficult to implement this integration of the Marketplaces with employer sponsored insurance. Hence the postponement for a year, at least, of the employer mandate.

3. Over Specificity

Ironically, some of the steps written into the ACA in attempt to smooth over the coherence issue wind up causing another set of problems because they turn out to over-specify solutions. One that has proved enormously vexing to many state Medicaid programs is trying to implement the concept of *benchmark benefits*.

The goal sounds good: create a single package of benefits that are similar across existing private insurance plans, new plans sold on the Marketplace and people newly eligible for Medicaid.

Again, this turns out to be harder to do than the concept. Part of issue is the concept fails to take into account that for the last 45 years, the private health insurance system has been finely tuned to filter out people with severe chronic illnesses, particularly mental health and substance abuse problems, and shunt them to Medicaid, and, to a lesser extent, Medicare.

Despite attempts to address these concerns in the portion of the ACA addressing benefit packages, the law ends up tying the benchmark for benefits more to the existing private insurance plans than the existing Medicaid benefits. In this construct, it is difficult to provide the level of mental health and substance abuse benefits that conventional Medicaid typically provides. These are services that many of the existing uninsured most desperately need. (Remember the newly Medicaid eligible are primarily poor, single people, which includes a disproportionately high percentage of people with mental health and substance abuse problems who previously did not get Medicaid only because they were not categorically eligible.)

In Illinois, we think we have figured out how to resolve this issue, but it has required literally weeks of intense discussion among HFS leadership, sister agencies, consultants, advocates and the Federal government. And we have not yet finalized.

4. Complexity

The issue is not really complexity per se, but the conflict of desire for simplicity with the real world needs. Two examples, which cut different ways.

As mentioned earlier, two weeks before October 1, the Federal Marketplace admitted that they were not going to be able to transfer applications from the Marketplace to Medicaid until November 1. This led, however, to a heated discussion between states and the Marketplace about the language on the notices should read. One issue was that the Marketplace was unwilling to include language advising clients that they did not need to worry because coverage under the ACA would not be effective until January 1 in any event. The federal argument was that some of the people might in fact be eligible under current standards and therefore the statement would be incorrect.

- On the one hand, that is absolutely true.
- On the other hand, that will be the vast minority of cases. And states are concerned that not including this calming feature will increase unnecessary traffic in state offices, lead to the filing of multiple applications and, in short, create unnecessary confusion that the states will have to clean up at a time when they are otherwise fully occupied.

Both views are correct. It is not obvious how to reconcile these differences.

Another more complicated example has to do with determining how to "simplify" the application process.

The basis of this issue is rooted in one of the ACA's basic premises, that it is possible to design a simple and easy on-line application that works like Amazon or Expedia. One of the notions was that this application could return a decision while the person was on line, the so-called "single seating" approach. Laudable, but not readily compatible with the kind of complex eligibility determinations described earlier.

The fundamental problem is that this concept fails to take into account the underlying difference in eligibility approach between the Marketplace and Medicaid. The Marketplace determines eligibility and premium level based primarily on a single call on income tax records from the most recent year preceding the year of insurance application--for 2014, either 2012 or 2011. Two other sources are consulted to make sure there are no gross inconsistencies, but the bulk of the lift comes from this retroactive look at IRS records. That works because the ACA also includes a mechanism to recoup any over/under payments when the applicant files income tax for the year of coverage.

Medicaid doesn't work that way. By law it is required to determine eligibility based on current circumstances. Nor does it include mechanisms for recapture. Consequently, the eligibility determination process for Medicaid is more stringent than for the Marketplace, with the stringency varying from state to state, from legislature to legislature.

And another complication: about half the states do determination of Supplemental Nutritional Assistance Programs (SNAP, formerly known as "food stamps") and cash assistance at the same time as they determine Medicaid eligibility. SNAP requires a face-to-face interview. There is no evidence the complexities this adds were considered by the framers of the ACA, even in passing.

For those 34 states that do not have their own Marketplace, these conceptual differences have led to persistent arguments over the last three years about the application process.

A somewhat baroque example from Illinois is illustrative: In August, months after our basic computer design was completed, HHS demanded we add a series of twenty-two very detailed questions that would apply only to applicants who were declared ineligible for Medicaid and referred to the Marketplace. We scrambled and inserted the questions.

Then, in mid-September at our final operational review from the Feds, they complained loudly that we had made the Medicaid application too complicated since most Medicaid applicants would never need to provide that information. While true, there is no way we could resolve the difficulty because the Illinois system requires the entire application to be compete before it determines eligibility. (Our Medicaid verification is too complex to be realistically determined at a "single seating" with existing tools. We try to make the experience for applicants manageable by collecting their information upfront, and then letting us resolve eligibility subsequently. Hence, we can not ask those questions *only* of people who have been determined ineligible because we don't know who those people are at the time we are collecting the information.)

The important point here is not the apparent inconsistency in Federal directions, however annoying. The important point is the implementation difficulties of trying to resolve multiple and to some degree conflicting objectives. No doubt there are theoretical solutions. But the implementer's world is the tool box at hand, bounded by time. Simplicity, under these constraints, turns out not to be very simple at all.

Implications for Evaluation

So, the stock and trade of academics is analysis and evaluation. I know right now faculty members and graduate students are all running to their computers to begin evaluating the ACA, like jet fighter pilots scrambling to their planes. Which is exactly as it should be.

But, as evaluations are getting under way, please consider the context.

Not that evaluations should ignore or gloss over problems. Useful evaluation is the only road to improvement. But consider some of the implications following from my previous comments.

- The ACA will be in a state of flux for years. The Federal Marketplace is not claiming even Day One full functionality until November 1, and they long-ago acknowledged that they never anticipated full functionality on Day One, Year One. In Illinois, for instance, we will have two more releases of our eligibility system between now and the end of February.

Then another release scheduled for June 2015. And we are starting to sketch out the release beyond that. Each will address major problems and issues that we know about before the first applicant tries our systems. We suspect that over the next few weeks we will discover new problems--and those will be addressed somewhere in this time frame. Which is the ACA implementation to evaluate?

- This is particularly problematic given the cycle time of program evaluation. Evaluations based on the first year of ACA coverage in 2014 probably won't appear in journals until 2016. By that time there will have been a world of changes. How useful will it be to pronounce findings on a version of the program that no longer practically exists.
- It seems likely that the ACA will still be politically radioactive over the next several years, certainly until after the 2016 election. While political issues often color policy analysis, the politics around the ACA seem particularly treacherous--and largely irrational. (Or, more accurately, are being played out on against a set of goals and objectives that have nothing to do with the healthcare coverage itself. And therefore all findings will find themselves employed in ways presumably not intended by the researchers.)

I am not sure what advice I would give those of you intrepid or foolish enough to be working on ACA related issues. Certainly a plea to very explicitly think about the confounding effects of the peculiar implementation process and how the results might be used in America's continuing food fight.

I might also suggest that researchers focus not on the specifics at some past period, but really think carefully about what questions can point the realistic way to an evolution toward something more sustainable. I don't see any likelihood I'm going to be around to implement the next leap forward, but some of you are young and at the beginning of your careers. Some of you should think about what research points the way to set of changes that are incremental enough to adopted, but big enough to be important. And some of you should be getting yourselves ready to implement those changes. Hopefully it won't be as challenging as these changes, but I wouldn't bet on it. Healthcare is more than one-sixth of the economy. There are always going to be a lot of people with some very large vested interests in anything anyone wants to change.

And Finally....

Thanks again for the opportunity to open this year's lecture series. Although it may have been hard to appreciate because of the *sturm und drang* surrounding it, last week was a truly historic milestone for those of us working in healthcare policy. I have been at it for almost 40 years now. I didn't think I would be around to participate in this kind of step. So I could not be more appreciative of the opportunity to talk to you about some of the challenges of implementing the ACA. I hope this serves as a useful introduction into the year's lecture series.