Economic Analysis

The Affordable Care Act: 5 Years Later

Amanda Augustine

- **The number of insured has increased, but healthcare providers struggle to accommodate the newly insured.**
- **States that have not expanded Medicaid forgo billions in federal payments and provide less access to care.**
- **ACA provisions regarding Medicare have resulted in cost savings and reduced inefficiencies.**
- **American businesses are expected to adjust compensation and pricing in response to the employer mandate.**

Life Before Reform

The Patient Protection and Affordable Care Act, signed into law in 2010, commonly called the Affordable Care Act (ACA) or Obamacare, represents the most significant overhaul of the U.S. healthcare system since Medicare and Medicaid were passed in the 1960s. The ACA was designed to correct several inefficiencies within the existing healthcare delivery and payment structure. In 2009, the OECD reported that healthcare spending in the U.S. accounted for 17.4% of its GDP—the highest among all OECD countries and much higher than the OECD average of 9.6%.[1] Despite this level of healthcare spending, the U.S. fared worse than most countries in health insurance coverage, with the lowest level of public coverage and the fourth lowest rate of overall coverage among all OECD countries.

The primary objective of the Affordable Care Act and Title I of the law is "Quality Affordable Healthcare for All Americans." This overarching objective can be broken down into the following goals: expanding health insurance coverage, improving the quality of healthcare, and reducing healthcare expenditures for the government and for businesses. Although the ACA has achieved its goal of expanding coverage, much work is yet to be done in improving access to quality healthcare and in reducing spending on healthcare.

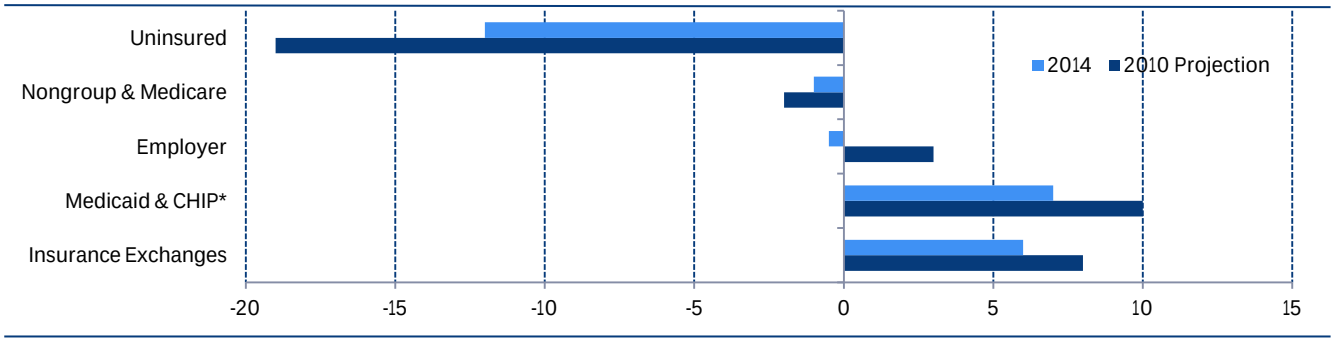
Where Are We Now?

The number of insured has increased, but not to the level anticipated in 2010.

Upon the passing of the ACA in March 2010, the Congressional Budget Office and Joint Committee on Taxation estimated that by 2014, 19 million people would gain insurance as a result of the law and that by 2019, this number would increase to 32 million Americans.[2] The actual number of those who gained insurance by 2014 was lower, mainly due to policy changes such as the Supreme Court's ruling that made state Medicaid expansion optional. By design, the ACA fails to expand coverage to certain groups of people, including unauthorized immigrants who are ineligible for subsidies and Medicaid benefits.

[1] http://www.oecd.org/els/health-systems/49105858.pdf
[2] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf

Chart 1
Changes in Coverage as a Result of ACA Provisions, 2014 (millions of people)

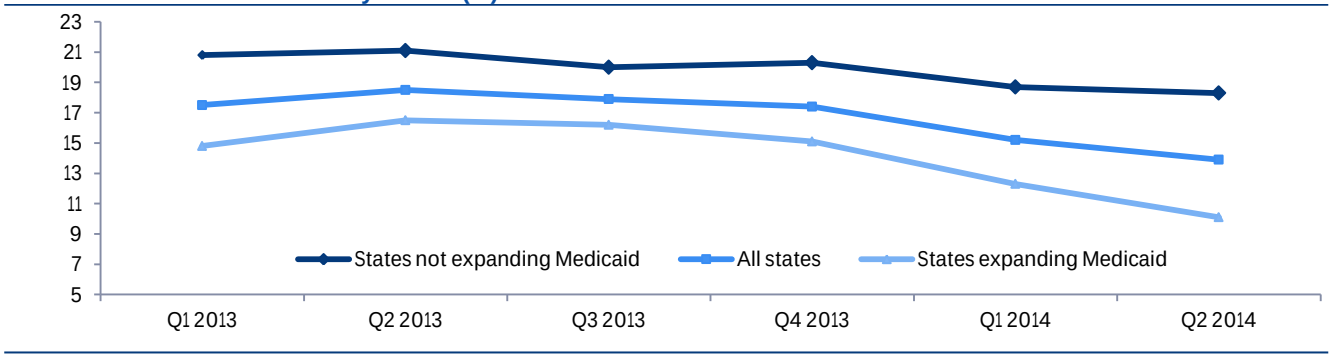


Source: Congressional Budget Office and the Joint Committee on Taxation

Pre-Existing Conditions: Although one of the goals of the ACA was to end discrimination against people with pre-existing or chronic conditions, coverage has been lower than expected for this at-risk group. Provisions relating to those with pre-existing conditions were scheduled to start in 2014. As a result, the ACA created the Pre-Existing Condition Insurance Plan (PCIP) to make health insurance available to those with pre-existing conditions before then. As of February 2013, when enrollment in the PCIP was suspended due to rising costs and limited funding, more than 114,000 Americans had enrolled in the plan.[3] This is below initial projections of total enrollment which varied between 200,000 and 400,000.[4]

Young People: One instance in which ACA provisions exceed expectations is in the number of young people insured. The ACA requires insurers that offer dependent coverage to make that coverage available until the age of 26; whereas, in the past, insurance plans could stop covering dependents at age 19, or at age 22 if they were full-time students. This provision was one of the first put into effect after the signing of the ACA; therefore, some of the best early data of the law's impact concerns the young adult segment. The share of uninsured 19-25 year olds has declined to 21% in 2014 from 34% in 2010. In 2010, the government's estimate of the number of previously uninsured individuals who would be newly covered under their parents' plans was only 1.7 million by 2013.[5] In actuality, the number of young adults gaining insurance as a result of the ACA was already over 3 million by mid-2012.[6]

Chart 2
Uninsurance Rate for Nonelderly Adults (%)



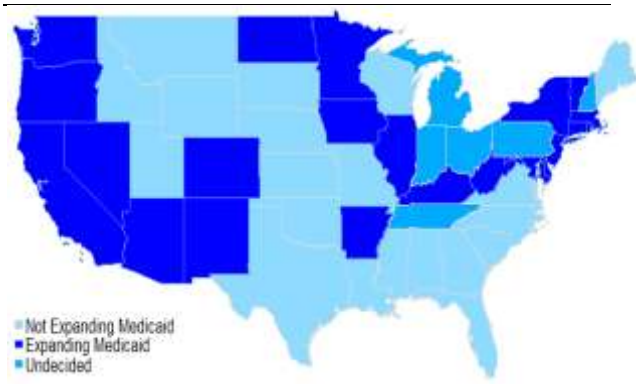
Source: Urban Institute Health Policy Center

[3] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pcip-enrollment.html
[4] http://www.gao.gov/new.items/d11662.pdf
[5] http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=23865
[6] http://aspe.hhs.gov/aspe/gaininginsurance/rb.cfm

Medicaid: Although the ACA expanded Medicaid coverage to include people with incomes up to 138% of the poverty level, this provision has experienced mixed success as the Supreme Court later ruled that Medicaid expansion was optional for states. Currently, 28 states (plus the District of Columbia) have chosen to expand Medicaid, while 15 have not, and 7 have not yet made a decision. The uninsured rate in states that have expanded Medicaid is 10.2% versus 15.1% in states that haven't.[7]

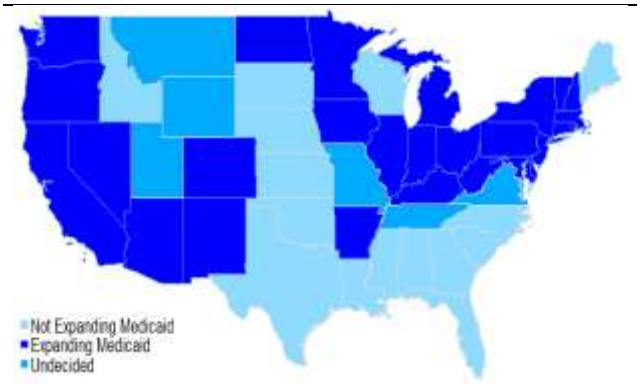
States that refuse to expand Medicaid forgo generous federal payments and could ultimately experience a decline in their human capital. A study in the New England Journal of Medicine reported, "State Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health."[8] To encourage states to expand Medicaid, the government offered to cover 100% of Medicaid expansion costs from 2014-2016, gradually decreasing to 90% in 2020 and beyond. States refusing to expand Medicaid forgo $8.4 billion of federal transfer payments through 2016, and will have 3.6 million fewer people insured as a result of opting out.[9] As shown in Charts 3 and 4, an increasing number of states have chosen to expand Medicaid, demonstrating that the majority of states, regardless of political affiliation, view expansion as favorable in terms of overall costs and savings.

Chart 3
Medicaid Expansion by State (as of 7/2013)



Source: Kaiser Family Foundation

Chart 4
Medicaid Expansion by State (as of 1/2015)



Source: Kaiser Family Foundation

Increased coverage does not mean increased access to healthcare.

The Affordable Care Act places its focus on getting more Americans insured, rather than making sure people receive the healthcare they need. About half of the insurers in the health insurance exchanges (or Marketplace) are either healthcare maintenance organizations or exclusive provider organizations, which only allow in-network care. In some cases, these plans allow their participants to go out of the network only in emergencies or through a lengthy appeals process; otherwise, participants are forced to pay 100% of expenses out-of-pocket for out-of-network care.

Although Marketplace plans must comply with federal and state requirements for network adequacy, they retain some flexibility to design narrower networks than those found in employer-sponsored plans. A study by the American Heart Association found that regional Marketplace plans varied widely in their coverage of physicians. The number of physicians covered in the plans' networks ranged from 8% in Los Angeles to 83% in

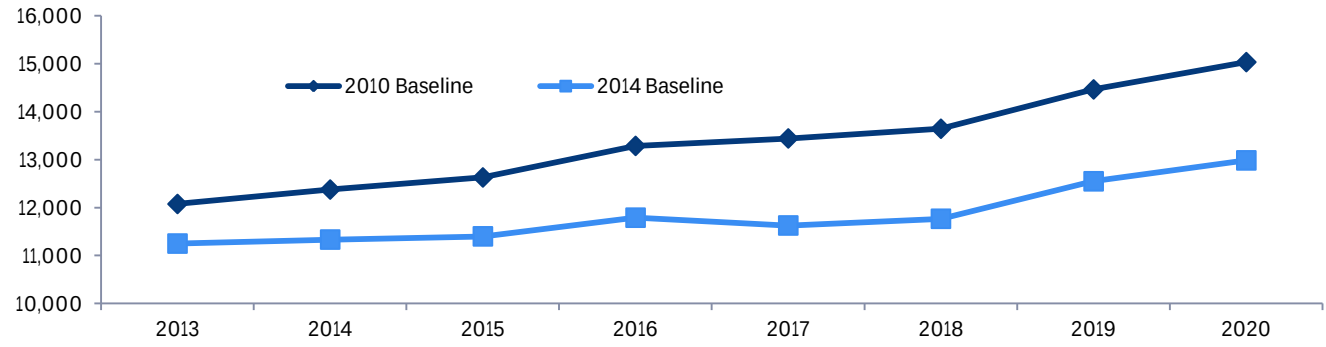
[7] http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.pdf
[8] http://www.nejm.org/doi/full/10.1056/NEJMsa1202099
[9] http://www.ncbi.nlm.nih.gov/pubmed/23733976

Philadelphia. In Los Angeles, none of the study's selected cardiologists were covered by the area's Marketplace plans.[10] Furthermore, the Department of Health and Human Services found that almost 50% of the providers listed as serving Medicaid patients could not offer appointments to enrollees. Of these providers, 43% claimed that they were not participating in the plan at the listed location, and 7% were not accepting new patients enrolled in the plan. Median wait times exceeded two weeks, with a quarter of providers having a wait time of more than one month.[11]

The evidence suggests that the current healthcare delivery system is not equipped and/or incentivized to handle the increasing number of insured patients. The ACA included a federally-funded temporary increase in Medicaid primary care reimbursement rates, which expired in 2014, but most states are not planning to continue this increase using their own funds in 2015.[12] This implies that physician reimbursements could fall by as much as 43%, further contributing to the lack of primary care which the increased number of Medicaid patients can expect.[13]

The ACA's Medicare provisions have successfully reduced waste and cut costs

Chart 5
Medicare Spending per Beneficiary, CBO Baselines ($)



Source: Congressional Budget Office

Several provisions of the ACA aim to reduce growth of healthcare spending, especially in regards to Medicare, which is the largest single purchaser of healthcare in the U.S. (23%).[14] For example, the Hospital Readmission Reduction program aims to reduce preventable patient readmissions by cutting government Medicare expenses for hospitals that have an excess number of patients that are readmitted within a month. More than 2,217 hospitals were penalized in the first year of the program, resulting in Medicare savings of about $280 million.[15]

The slowdown in Medicare program spending since the passage of the ACA has been substantial; as shown in Chart 5, Medicare spending in 2013 was about $800 lower per person than was expected in 2010, and is expected to be over $2,000 lower in 2020 than originally projected.[16] This bending of the cost curve can be partly attributed to reductions in Medicare payments to providers and to reforms that aim to improve efficiency and

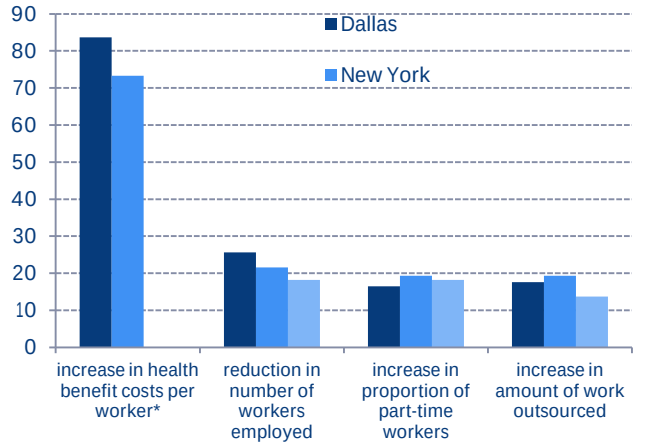
[10] http://www.heart.org/idc/groups/public/@wcm/@adv/documents/downloadable/ucm_468318.pdf
[11] http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf
[12] http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015/
[13] http://www.urban.org/UploadedPDF/2000025-Reversing-the-Medicaid-Fee-Bump.pdf
[14] http://www.medpac.gov/documents/publications/june-2014-data-book-section-1-national-health-care-and-medicare-spending.pdf?sfvrsn=2
[15] http://kaiserhealthnews.org/news/medicare-revises-hospitals-readmissions-penalties/
[16] http://www.cbo.gov/sites/default/files/cbofiles/attachments/MedicareAugust2010FactSheet.pdf, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf

reduce costs, such as the Hospital Value-Based Purchasing Program. This program, implemented in 2012, links a portion of hospitals' Medicare payments to performance on process quality measures, such as whether a patient received an antibiotic prior to surgery, and on patient experience measures, such as responsiveness of hospital staff to patients' needs. By the end of 2013, 1,500 hospitals were penalized for their subpar quality rankings through a reduction in their Medicare payment rate.[17] ACA reforms aimed at cutting costs, while reducing inefficiencies, could be contributing to low healthcare inflation, which in 2013, was at the lowest level since the government began keeping track in 1960.

Although specific provisions seek to reduce spending, estimates suggest that overall healthcare expenditures will continue to grow, albeit at a slower pace. ACA coverage expansions coupled with the aging population are expected to drive growth in public healthcare spending in the future; healthcare expenditures are projected to be 19% of GDP in 2023, up from 17% in 2012.[18]

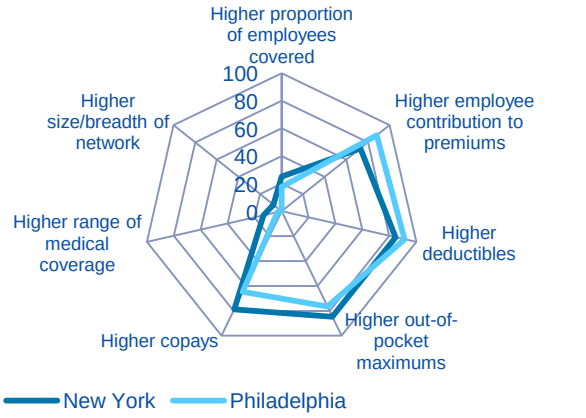
American businesses plan to pass on higher healthcare costs to employees and consumers.

Chart 6
Fed Survey Results 2014: Effects of ACA on Businesses (% of respondents)



Source: Federal Reserve Bank of Dallas, Federal Reserve Bank of New York, Federal Reserve Bank of Philadelphia
*Data n/a in Philadelphia survey

Chart 7
Fed Survey Results 2014: Modifications to Health Coverage Policies (% of respondents)*



Source: Federal Reserve Bank of New York, Federal Reserve Bank of Philadelphia
*Data n/a in Dallas survey

As the employer mandate recently went into effect, little data is available on the response of businesses to this ACA provision. Federal Reserve surveys show that most businesses expect to make modifications to their current healthcare plan, as the ACA had raised their healthcare costs per worker. The large majority of businesses plan to pass on these higher healthcare costs to their employees in the form of higher premiums, deductibles, and copays. Surveys also report that an average of 34% of businesses plan to increase prices, thus passing on higher labor costs to consumers.[19]

[17] http://kaiserhealthnews.org/news/value-based-purchasing-medicare/
[18] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/Downloads/Proj2013.pdf
[19] http://www.dallasfed.org/microsites/research/surveys/tmos/2014/1408/specquest.cfm, http://www.newyorkfed.org/survey/business_leaders/2014/2014_08Supplemental.pdf, http://www.philadelphiafed.org/research-and-data/regional-economy/business-outlook-survey/2014/bos0814.cfm#sp

One of the biggest challenges for small businesses will be determining whether to hire above the arbitrary threshold of 50 full-time employees. The employer mandate, which takes effect this year, requires employers with 50 or more full-time employees to offer health insurance to their workers. Legislation has recently been introduced to change the definition of a full-time employee from 30 hours a week, as defined by the ACA, to 40 hours. This would better reflect the reality of the American workplace, as the average number of hours worked by full-time employees is 47 per week.[20]

Bottom Line

Despite the promising increase in the number of insured nationwide, access to quality healthcare is still out of reach for many Americans. The supply of providers will take time to adjust to the growing demand for healthcare by the newly insured; in the meantime, further efforts should be made to incentivize providers to attend to patients who have benefited from Medicaid expansion and other provisions. Congress should consider adding more provisions that reward healthcare providers for reducing inefficiencies and improving the quality of their care, such as the Hospital Value-Based Purchasing Program. As small businesses expect to be impacted by the employer mandate, their burden can be lightened by adjusting the threshold of full-time employees. The ACA has been successful in expanding coverage, especially to the most vulnerable Americans; therefore, efforts should be made to improve upon its existing provisions.

[20] http://www.gallup.com/poll/175286/hour-workweek-actually-longer-seven-hours.aspx