The Affordable Care Act: Success or Failure?
Outline

• The logic of health insurance
• Major provisions of the Affordable Care Act
• Implementation of the Affordable Care Act to date
• What’s next?
The Logic of Health Insurance
Logic of Health Insurance: Beneficiaries

- Prevent economic calamity (stop big losses)
- Make expenses predictable (small copays, deductibles, coinsurance, and charges for share of premium vs. periodic large payments when services needed)
- Buy health care (don’t put off what should be done now)
  - Across continuum from preventive care at one end through chemotherapy at the other
- Buy health (and ability to be able to do things that are valued)

Whether having health insurance buys health is beside the point.
Logic of Health Insurance: Health Plans

• Stay in business (collect more in premiums than pay out for health care plus administrative overhead)
  – Make expenses predictable (premium costs and beneficiary cost sharing based on reliable estimates of usage)
  – Minimize costs
  • Achieve a good actuarial mix of beneficiaries
    – Old system: avoid people with pre-existing conditions
    – New system: entice more people who are young to offset older and sicker
  • Lower utilization
    – Old system: don’t provide all services, e.g. mental health, maternity
    – Old and new: use of cost sharing, utilization review, etc.

• Pay providers less
  – Selective contracting with pharmacies, hospitals, doctors
Logic of Health Insurance: Health Providers

• Stay in business (collect more than it costs to provide services)
  – Collect more from health plans (negotiate higher rates)
  – Reduce uncompensated care
  – Provide a mix of services that is more profitable
  – Reduce costs of providing services (negotiate with suppliers, including employees)

*AMA and American Hospital Association were strong advocates for the ACA because it promised to reduce the amount of uncompensated care.*
ACA Bargain

• Extend benefits of group plans to individual insurance markets
  – Create larger pools to increase predictability

• Provide subsidies to encourage more people to obtain health insurance

• Alter mix within pools
  – Create healthier pools to amortize cost of adding people with pre-existing condition clauses
Benefit of Creating Larger Pools

![Boxplot showing the distribution of total healthcare expenditures across different group sizes.](image-url)
Benefit of Altering Mix within Pools:
Annual Medical Care Expenditures, by Age, U.S., 2009

Source: Analysis of 2009 Medical Expenditures Panel Survey
Major Provisions of the Affordable Care Act
It Takes Three Branches . . .
ACA in Brief

Insurance Reform
- More people covered
  - Medicaid expansion
- More benefits & protections
  - Insurance exchanges
- Lower costs (consumers & government)
  - Guaranteed issue
- Preventive services cov’g
  - Kids under 26 covered
- Exchange subsidies
  - Min cov’g provision

Health System Reform
- Improved quality & efficiency
  - Accountable Care Orgs. (ACOs)
- Stronger workforce & infrastructure
  - Comm.- & school-based-health centers
- Greater focus on public health & prevention
  - Prevention & Public Health Fund
- Medical homes pilots
  - Community Transform. Grants
- Medicaid provider payments
  - Public education campaigns
- Medical loss ratio (MLR)
  - NHSC loan repayment program
- Premium rate review
  - Community health needs assessments
- Quality measure devel. & use
  - Nutritional labeling
- Incentive payments
  - Dual eligibles care coord.
- Medicare Advantage
  - Public health workforce devel.
- Prescription drug rebates
Two Major Sets of Provisions

- Insurance reform
  - Expand access
  - Provide better coverage
  - Control costs

- Health system reform
  - Improve quality and efficiency
  - Strengthen workforce and infrastructure
  - More emphasis on public health and prevention
Insurance Reform
The Individual Mandate

• Most citizens and legal immigrants must have coverage

• Tax penalty if no coverage. In 2014 the higher of
  • $95 per adult ($47.50 per child)
  • 1% of annual household income

• Exceptions for
  • Gaps of less than 3 months
  • Financial hardship
  • Religious objection
Rules for All Insurance Markets

- Prohibitions on
  - Lifetime limits on coverage
  - Annual limits on coverage
  - Cost sharing for recommended preventive services (new policies only)
Individual Insurance Market Rules

- Guaranteed issue
- Cannot deny coverage for preexisting conditions
- Cannot cancel coverage without proving fraud
- Premiums can vary only based on
  - Location
  - Age - 3 age bands
  - Tobacco use (not in California)
Health Insurance Exchanges

• Available to
  • Individuals and families
  • Small business

• States chose whether to
  • Establish their own exchange
  • Participate in the federal exchange
Health Insurance Exchanges

- State regulated “insurance marketplaces”
  - Can compare plans by quality and cost
  - All plans offer the same “essential benefits”
  - Four standardized benefit designs
Health Insurance Exchanges: Essential Health Benefits

- Hospitalization
- Emergency services
- Outpatient care
- Prescription drugs
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services
- Rehabilitative and habilitative services and devices
- Mental health and substance use disorder services
- Pediatric vision and dental
Health Insurance Exchanges: Metal Tiers

- Bronze: 60% Plan Pays, 40% Consumer Pays
- Silver: 70% Plan Pays, 30% Consumer Pays
- Gold: 80% Plan Pays, 20% Consumer Pays
- Platinum: 90% Plan Pays, 10% Consumer Pays
Health Insurance Exchanges: Subsidies

- Subsidies for persons & families with incomes 133-400% federal poverty level ($31,322 to $94,200 for a family of four)
  - Premium tax credit toward purchase of insurance
    - Contributions capped at 2% to 9.5% of income
    - Tied to lowest cost silver plan
  - Cost-sharing tax credit (rebate on Out of Pocket costs) - incomes 133% to 250% federal poverty level
Medicaid Expansion

- Historically, Medicaid eligibility varied from state to state & generally excluded low-income adults without children.

- Under the ACA, all citizens with incomes below 133% FPL ($31,322 for a family of four) eligible for Medicaid.

- The Supreme Court ruled that the federal government cannot compel states to expand Medicaid.
Health System Reform
Medicaid Reimbursement

- Concern about access to primary care for new Medicaid enrollees
  - Only 66% of primary care physicians in the USA accepted new Medicaid patients in 2011
  - Medicaid reimbursement rates are lower than Medicare and private insurance rates
    - On average Medicaid fees are 66% of Medicare fees

Sources: KCMU/Urban Institute Medicaid Physician Fee Surveys, National Ambulatory Medical Care Survey
Medicaid Reimbursement

• Increases Medicaid fee-for-service reimbursement for primary care physicians to Medicare rates
  • States receive 100% federal matching funds
  • Only authorized for 2013 and 2014

• Health Homes
  • Integrate and coordinate all primary, acute, behavioral health, and long-term services and supports for persons with chronic conditions
  • State Medicaid agencies receive a 90% match from the federal government
Medicare Reimbursement

• Bonus payments of 10% for
  • Primary care providers
  • General surgeons in health professional shortage areas

• Reduce payments to hospitals for readmissions within 30 days

• Reduce payments for hospital acquired conditions
Medicare Reimbursement

• Bundled payment pilot projects
  • Pay for episodes of care (3 days prior to hospitalization to 30 days post-discharge)
  • Single payment for inpatient, hospital outpatient, physician services, and post-acute care

• Accountable care organizations
  • Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients
Delivery System Reform

- Establishes new entities to assess the impact of innovations in care delivery
  - Patient Centered Outcomes Research Institute
  - Center for Medicare and Medicaid Innovation
Health Workforce Development

• Health workforce planning

• Scholarship & loan repayment programs

• Grants to health professions schools to
  • Increase supply in high priority professions
  • Improve racial/ethnic diversity
  • Enhance preparation for practice in underserved areas

• Changes Medicare graduate medical education payments to expand training in
  • Primary care
  • Ambulatory settings
ACA Implementation to Date
Medicaid

• 26 states and the District of Columbia have expanded eligibility for Medicaid

• Under debate in IN, MO, PA, UT, VA

• California and some other states transferred persons from other state programs into Medicaid
Medicaid

- Do not have good data on new enrollment yet. HHS data lumps three groups
  - Renewals for existing enrollees
  - Newly enrolled but eligible under pre-ACA rules
  - Newly enrolled due to eligibility expansion
Health Insurance Exchanges

• 16 states and the District of Columbia established their own health insurance exchanges

• 34 states rely on the federal exchange

• Number of states relying on the federal exchange exceeded projections
Health Insurance Exchanges

• Initial roll out was a flop
  • Federal exchange website not reliable for the first two months
  • Covered California’s website worked better but not problem free
  • A few state exchanges’ websites still aren’t working
Health Insurance Exchanges

- An estimated 7.5 million Americans have obtained health insurance through an exchange

- California has enrolled > 1.2 million persons - more than any other state

- No solid data yet on how many exchange enrollees were previously uninsured.
  - Some who previously had individual insurance may have switched to an exchange to obtain more affordable or more comprehensive coverage
Health Insurance Exchanges

• Enrollment trends vary by age and ethnicity

• Early enrollees were disproportionately over age 50 years but enrollment of young adults rose substantially as the deadline approached

• Enrollment of Latinos grew over time but is still lower than among other ethnic groups
Health Insurance Exchanges

March 30, 2014 | 7:11 a.m.

Los Angeles Times

Who’s covered in California?

Most numbers indicate that enrollment in Covered California has exceeded expectations.

Projected enrollment | Total enrolled

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<tr>
<th>Ethnicity and race</th>
<th>Figures in thousands</th>
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<tr>
<td>White</td>
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<tr>
<td>58% more</td>
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<tr>
<td>Asian</td>
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<td>121% more</td>
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<td>4% less</td>
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<tr>
<td>Other</td>
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<tr>
<td>5% less</td>
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<table>
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<th>Age</th>
<th>Figures in thousands</th>
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<td>55-64</td>
<td>100</td>
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<td>90% more</td>
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Note: Ethnicity and race data are as of March 17 and don’t reflect about 215,000 enrollees who didn’t specify that information. Age figures based on March 1 data. Projections are for six months ending March 31. Source: Covered California. Graphics reporting by Chad Terhune. Graphic by Raoul Rafaña Los Angeles Times
Rate of Uninsurance May be Falling

Source: Gallup Healthways Well-being Index
Delivery System Reform

• The ACA has been an catalyst for efforts to improve health care value
  • Medicare payment policies compelling hospitals to focus on reducing readmissions and health care acquired infections
  • Center for Medicare and Medicaid Innovation is providing substantial funding for 7 categories of innovations

• Early findings are encouraging but implementation is challenging
Delivery System Reform

- Rate of increase in health care expenditures has slowed

- Unclear whether the current slowdown will be permanent

- Need to watch what happens as:
  - The economy rebounds
  - The number of persons with health insurance increases
Average Annual Percent Change in National Health Expenditures, 1960-2012

What’s Next?
Medicaid

- Big questions about access to providers

- Some states that did not expand Medicaid in 2014 may do so in 2015
  - Governors do not like to leave federal funds on the table
  - Elections may change the balance of power in some states
  - Obama administration may allow more states to purchase private coverage
Health Insurance Exchanges

- Some insurers plan to seek double digit premium increases but increases may be attenuated due to
  - Competition with other health plans sold in exchanges may limit increases
  - Risk adjustment for health plans with sicker enrollees than average
Health Insurance Exchanges

• Churn between the exchanges and Medicaid is a bigger concern
  – UC-Berkeley Labor Center estimates that 42.5% to 46.7% of Covered California enrollees will leave within 12 months
  – Most will leave because they become eligible for Medicaid or obtain job-based coverage
  – Unclear how seamless transitions between Medicaid and exchange coverage will be

Dietz, Graham-Squire, and Jacobs, 2014
http://laborcenter.berkeley.edu/healthcare/churn_enrollment.pdf
Employers

• Implementation of employer mandate delayed
  • 2015 for firms with > 100 full-time employees
  • 2016 for firms with 50 – 99 full-time employees

• Cadillac tax for high cost employer health plans

• More employers may stop offering health insurance
Conclusion

• The ACA is stimulating major reforms in
  • Health insurance
  • Health care delivery

• These reforms have potential to improve
  • Access to care
  • Value (health outcomes per $ spent)

• Substantial variation in implementation due to
  • State discretion re Medicaid expansion and health insurance exchanges
  • Use of demonstration projects to test new models