The Rollout: An Update on the Affordable Care Act

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JUNE 18, 2014

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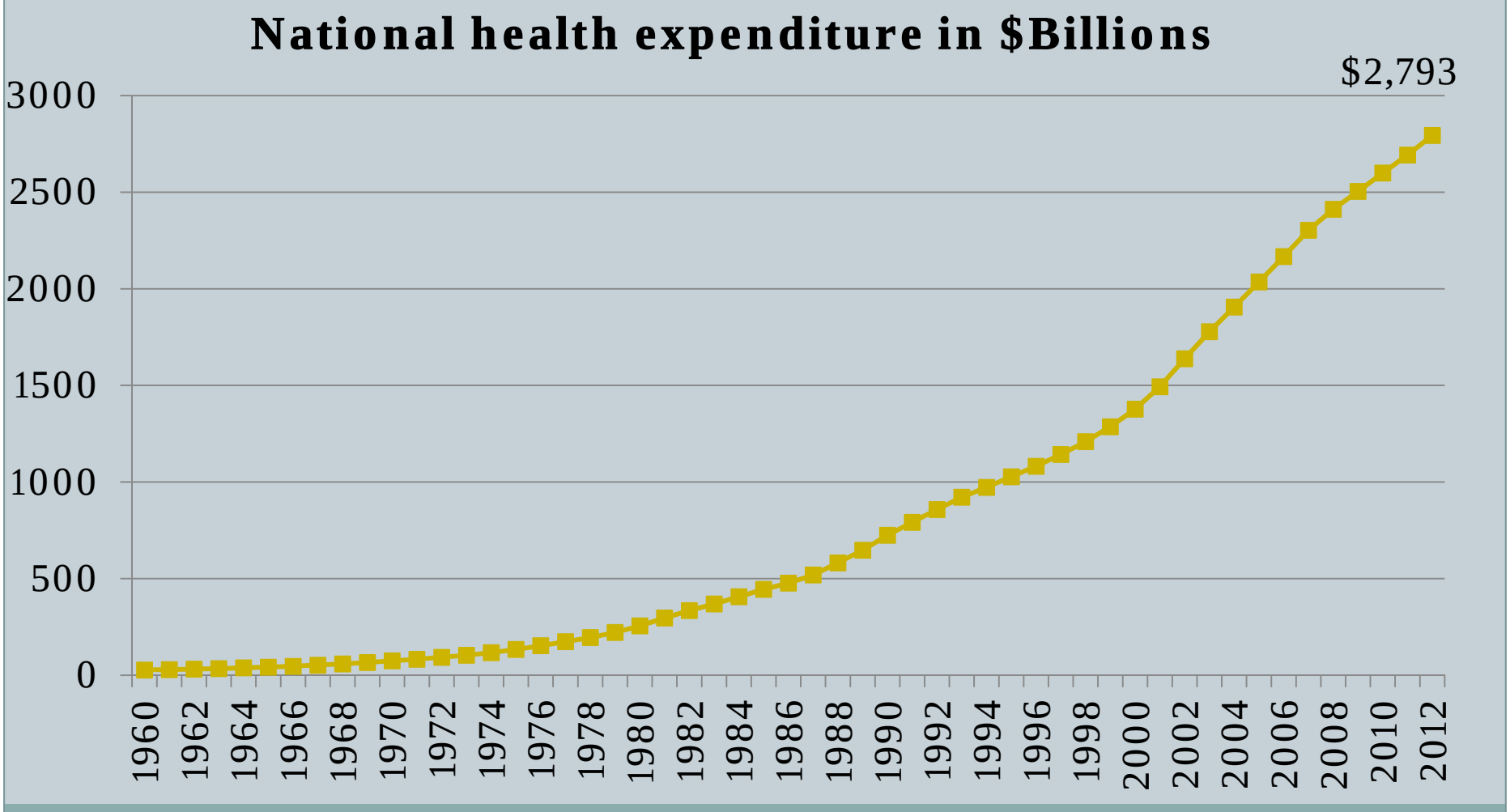
Outline

- Why reform health care?
- What are the current results of the ACA?
  - Changes in Health Insurance
  - Effect on Demand
  - Effect on Costs
  - Effect on Outcomes
- What can we expect in the future?

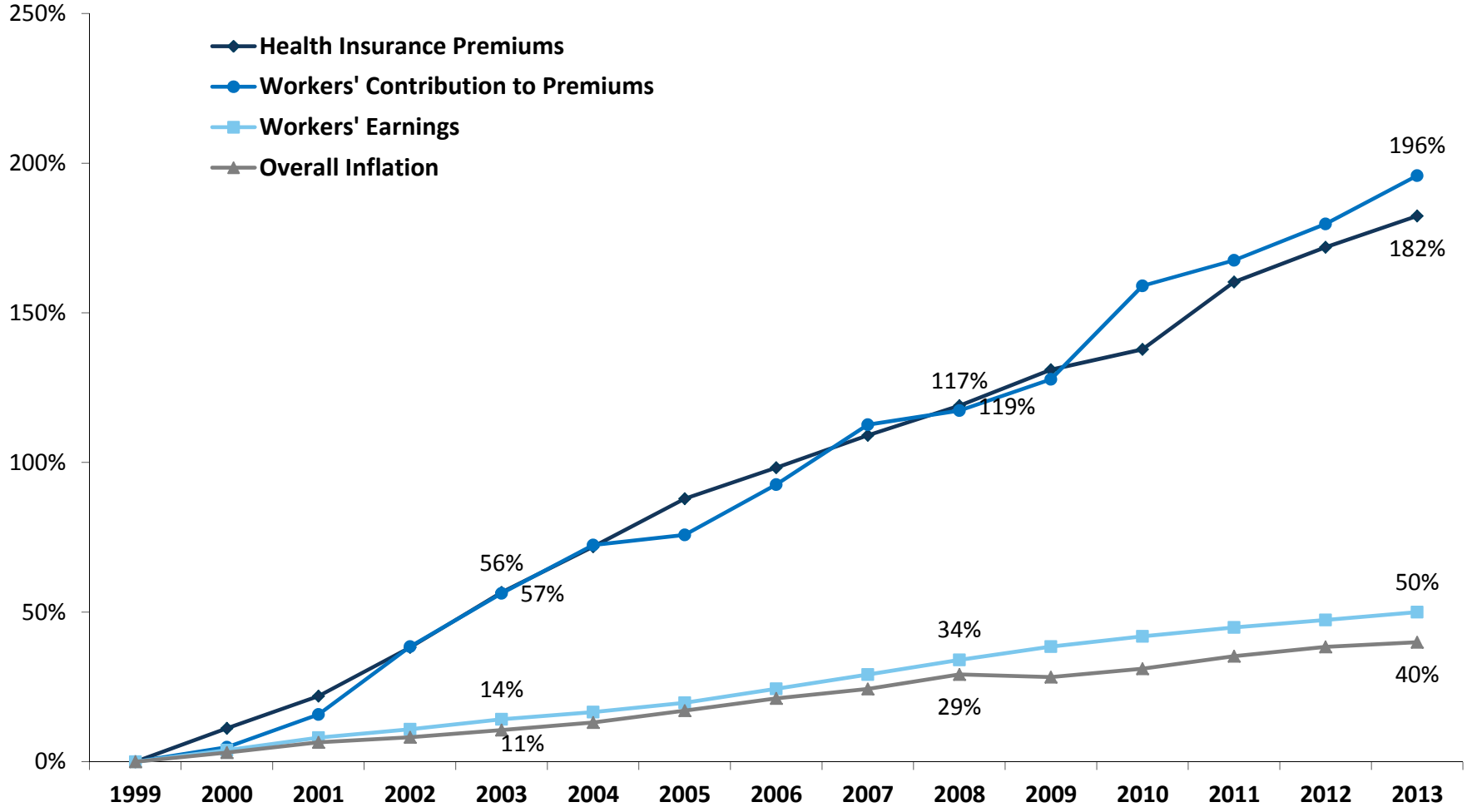
Why Reform Health Care?

Rising Health Care Costs



Source: National Health Expenditures, Center for Medicare and Medicaid Services

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2013



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2013. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2013 (April to April).

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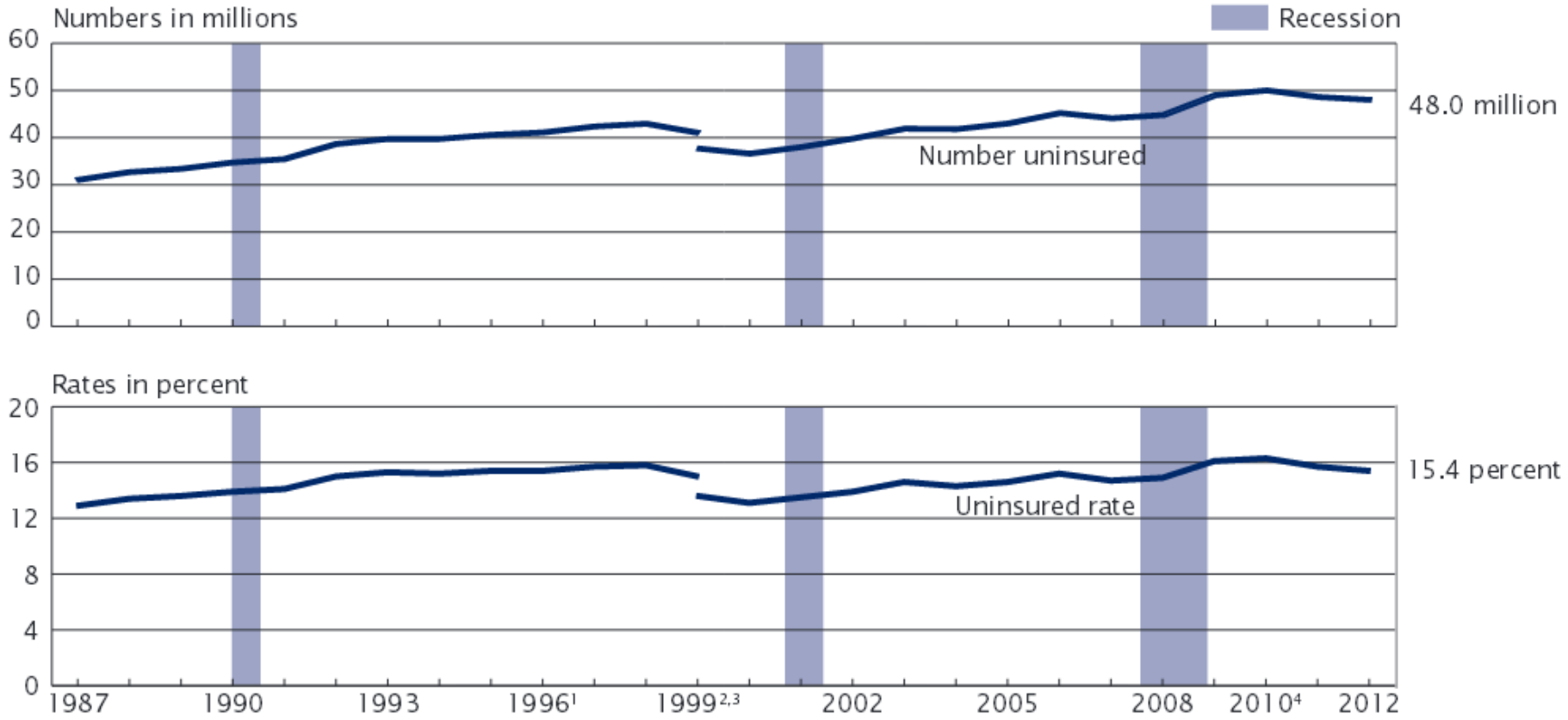
Figure 8.

Number Uninsured and Uninsured Rate: 1987 to 2012



[1] The data for 1996 through 1999 were revised using an approximation method for consistency with the revision to the 2004 and 2005 estimates.

[2] Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions, which were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.

[3] The data for 1999 through 2009 were revised to reflect the results of enhancements to the editing process.

[4] Implementation of 2010 Census population controls.

Note: Respondents were not asked detailed health insurance questions before the 1988 CPS.
The data points are placed at the midpoints of the respective years. For information on recessions, see Appendix A.
For information on confidentiality protection, sampling error, nonsampling error, and definitions, see <www.census.gov/prod/techdoc/cps/cpsmar13.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 1988 to 2013 Annual Social and Economic Supplements.

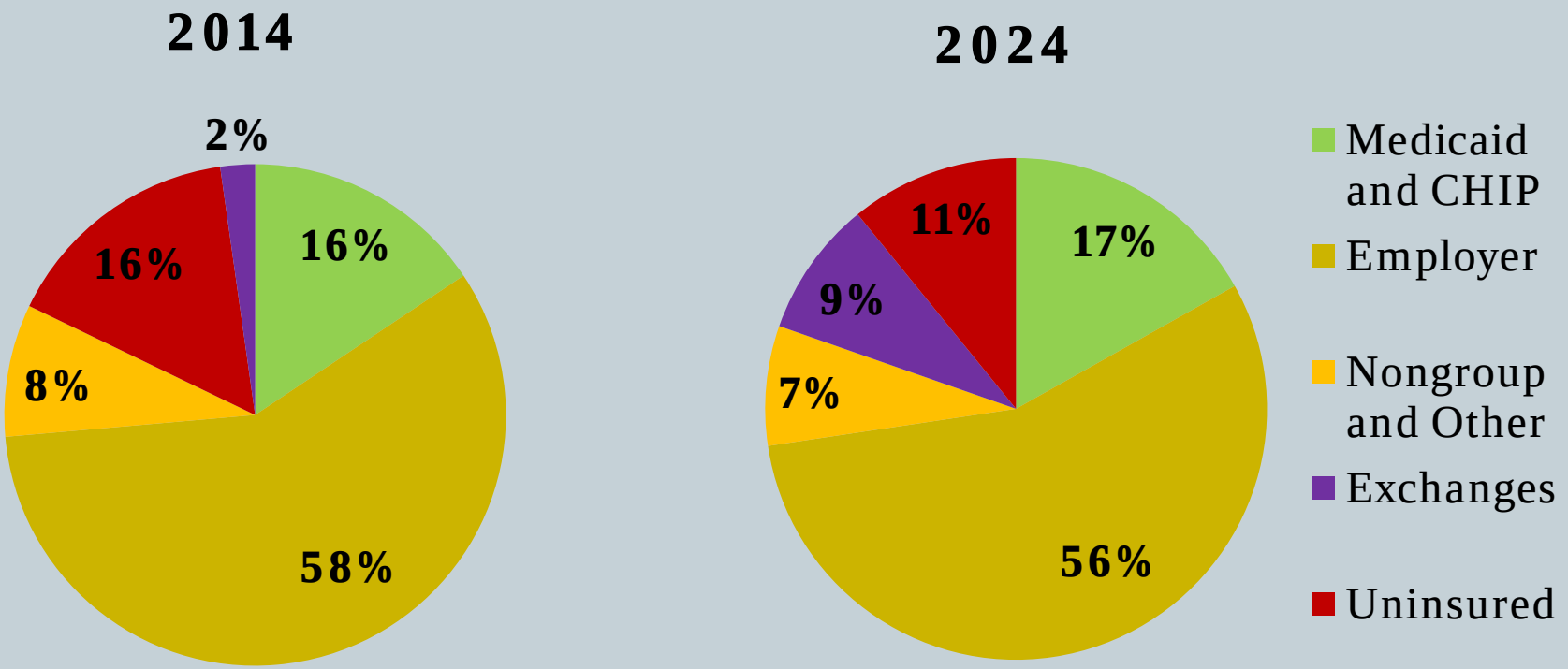
Changes in Health Insurance

Predicted Changes in Insurance Coverage under the ACA Millions of People

	2014	2024
Medicaid and CHIP	7	13
Employer	-.5	-7
Nongroup and Other	-1	-5
Exchanges	6	25
Uninsured	-12	-26

Source: Congressional Budget Office, April 2014.

Predicted coverage changes



CBO estimates that 26 million will gain insurance by 2024.

89% of Americans will be insured.

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Changes in Health Insurance

INDIVIDUAL INSURANCE: PRIVATE MARKET

Private market

- Number of people who purchase private coverage was about 29% higher by the end of March than it was in December 2013.
- Estimates that at least 15 million people are insured through the private market.
- Coverage for the off-exchange plans is on average 40% more costly than the exchange-based versions.

Source: Kaiser Family Foundation and Geneson et.al., HealthPocket, 6/5/2014

Changes in Health Insurance

INDIVIDUAL INSURANCE: EXCHANGES

Health Exchange Enrollment

- HHS in May 1st report said enrollment through the ACA's exchanges exceeded 8 million U.S. residents.
  - 2.2 million were 18 to 34 years old (28%)
- Estimates from insurers, suggest that payments have been received from around 80% of people who had selected health plans.
  - National Journal, 4/2/2014
- By this estimate, about 6.4 million have actually paid for insurance through the exchanges.

Variability in Insurance Exchange Options by State

- California, Colorado, Illinois, and Maryland have attracted a range of insurers.
- 12 insurers will offer plans in Oregon.
  - Premiums from $169 to $422 monthly for 40 year old nonsmoker
- In Arkansas, Maine & Vermont, only 2 insurers proposed selling policies.

Source: *Begley/Humer Reuters 5/17*

Variability in Insurance Exchange Options by County

- 515 counties across 15 states have only 1 insurer in exchange marketplace.
- Same plan may cost quite a bit more than in nearby county with competing insurers.
  - e.g. $200 less inside Tampa than in other FL county
- These counties tend to have lower average household earnings.

Source: Martin/Weaver, "For Many, Few Health-Plan Choices, High Premiums on Online Exchanges," *Wall Street Journal* 2/12/2014

Growing Competition in the Exchanges

- Several insurers that limited offerings or did not participate in 2014 are joining or expanding offerings in 2015.
  - UnitedHealth Group & Cigna intend to offer plans in more states.
  - WellPoint & Aetna will continue offering policies.
  - Several smaller insurers have noted that they see opportunities for expansion, especially in states with limited competition.
- Insurers must notify the federal government soon about their plans to participate in the federal exchange.

Source: Abelson, "Insurers Once on the Fence Plan to Join Health Exchanges in '15," *New York Times*, 5/25

Changes in Health Insurance

EMPLOYER SPONSORED INSURANCE

Changes in ESI

- Small business tax credit for low-wage firms
- Penalties for large employers who don't offer coverage
  - 100+ FTE employees in 2015
  - 50+ FTE employees in 2016

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Changes in Per-capita Employer Spending Due to the ACA, Simulated as if the ACA is Fully Implemented in 2012

		Without Reform	ACA	% Difference
All Employers	Total per-capita employer spending	$3,653	$3,637	-0.4%
Small firms (100 or fewer employees)	Total per-capita employer spending	$4,126	$3,824	-7.3%
Mid-size firms (101-1,000 employees)	Total per-capita employer spending	$3,509	$3,672	4.6%
Large firms (More than 1,000 employees)	Total per-capita employer spending	$3,683	$3,695	0.3%

Note: Persons reporting ESI coverage in households where no policyholder is identified are included in the total calculations but not the firm size groups.
Source: Urban Institute Analysis, HIPSM 2012

Changes in ESI

- Little impact on employer-sponsored health coverage so far.
- The ACA's impending excise tax on "Cadillac" plans may force employers to scale back health plans in 2018.

Source: Millman, "Wonkblog," *Washington Post*, 5/21

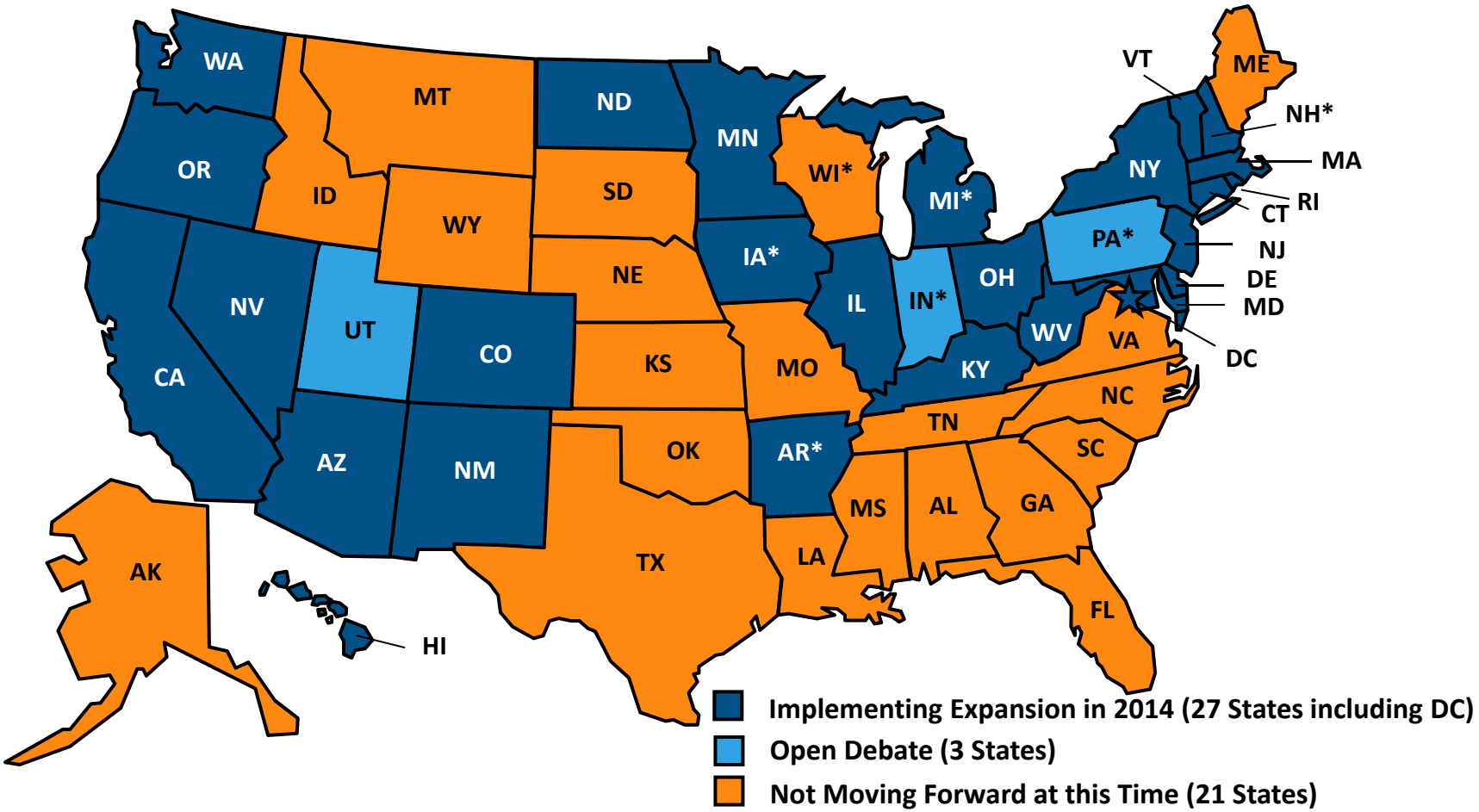
Changes in Health Insurance

THE MEDICAID EXPANSION

Medicaid Expansion

- Optional Medicaid expansions up to 138% of FPL
  - Financed almost entirely by federal government
  - 2013 poverty threshold = $23,550 for a family of 4
- 15.8 million were expected to gain insurance coverage through Medicaid under the ACA if all states expanded

Current Status of State Medicaid Expansion Decisions, 2014



NOTES: Data are as of June 10, 2014. *AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and implemented in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here. States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.

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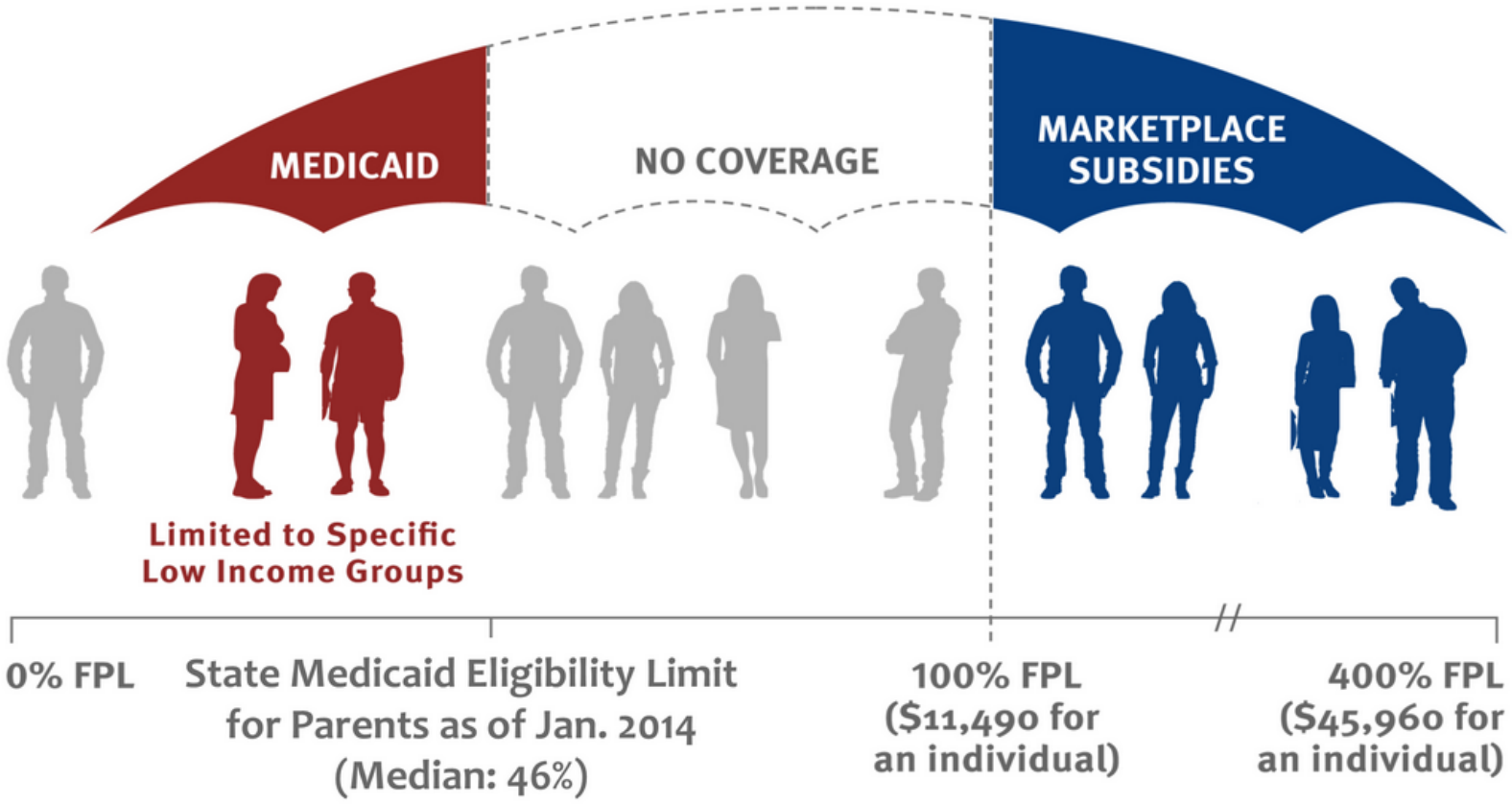
In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid .

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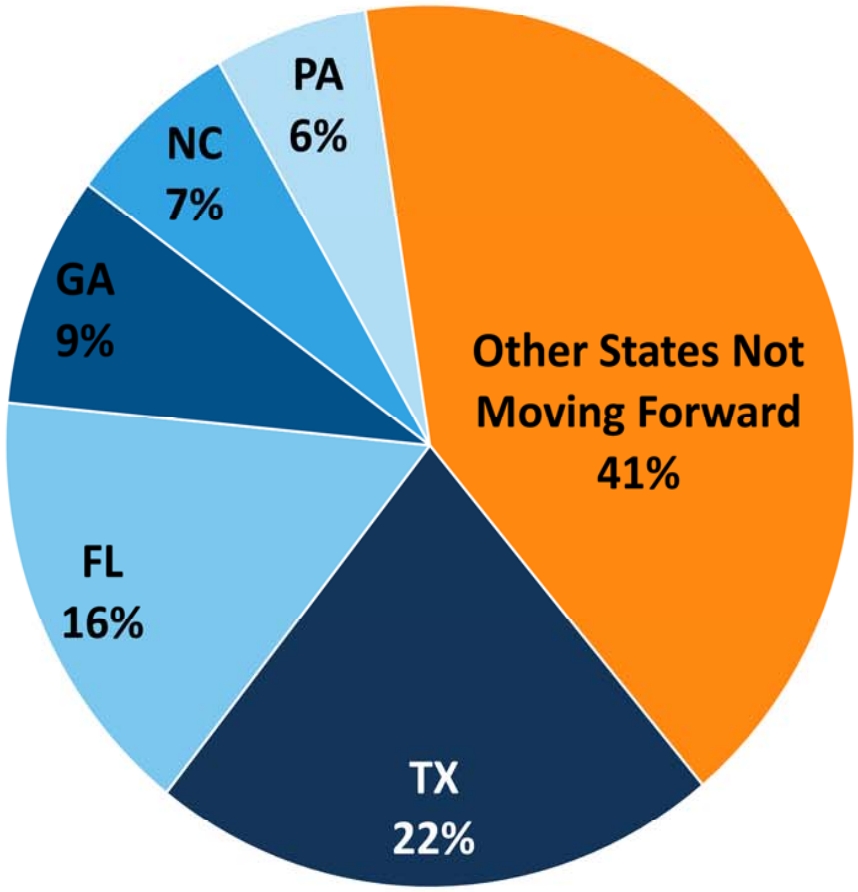
Without Medicaid expansion, 4.8 million uninsured nonelderly adults below poverty may fall into the coverage gap.



4.8 Million in the Coverage Gap

Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are not lawfully present. The poverty level for a family of three in 2013 is $19,530.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey. See Methods Box for more detail.

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Costs of forgoing a Medicaid expansion

Outcome	If expanded in opt-out states	If expanded in Texas
Depression	-712,037	-184,192
Catastrophic medical expenditures	-240,700	-62,610
Mortality (high estimate)	-17,104	-3,035
Mortality (low estimate)	-7,115	-1,840

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. (Sommers et al. NEJM 2012)

Table data source: Dickman et. al., Health Affairs Blog, 01/30/2014

Costs of forgoing a Medicaid expansion

- Medicaid expansion comes from 100% federal funding 2014-2016, falling to 90% in 2020 onwards.
- Texas taxpayers will continue to foot the bill for uncompensated health care.
- Texas will forgo about $9.6 billion in federal funding by year 2022

Source: The Commonwealth Fund

Effect on Health Care Demand

More insurance raises demand for care

- Evidence from research (Buchmueller et al., *Medical Care Research and Review*, 2005)
  - Outpatient visits
    - 1-2 additional visits per year on average
    - Bigger response for women than men
    - Bigger response of going from uninsured to Medicaid than from uninsured to private insurance
  - Inpatient utilization
    - Small but significant increase in demand of .16 to .24 days per year going from uninsured to privately insured

How much will demand for PCPs rise?

Hofer, Abraham and Moscovice, *Milbank Quarterly* 2011

Research Questions

- How much additional primary care will be demanded across states, given the coverage expansion?
- How many more primary care physicians will be needed?

Methods

- Medical Expenditure Panel Survey, American Community Survey, and MGMA productivity data

State-Level Estimates of the Uninsured, Predicted Increase in Annual Visits, and Corresponding Primary Care Physician Workforce Demand

State	Population Uninsured (scaled to 2019)	Estimated Rise in Primary Care Use		Estimated Number of New PCPs needed		Existing Supply of PCPs (2008 estimates)
		Lower Bound	Upper Bound	Lower Bound	Upper Bound	
California	7,760,441	2,134,621	3,447,498	612	985	34,351
New York	2,719,336	697,205	1,105,810	199	316	25,151
Texas	6,948,140	1,980,615	3,229,455	566	923	17,332
Total	54,000,000	15,073,621	24,300,749	4,307	6,940	279,664

Source: Hofer et. al., *Milbank Quarterly*, 2011

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Effect on Health Care Costs

Effect of the ACA Insurance Provisions on Federal Spending 2015-2024 (Billions)

Medicaid and CHIP	792
Exchanges	1,032
Small Employer Tax Credits	15
GROSS COST OF COVERAGE PROVISIONS	1,839
Penalty Payments by Uninsured Individuals	-46
Penalty Payments by Employers	-139
Excise Tax on High-Premium Insurance Plans	-120
Other Effects on Tax Revenues and Outlays	-152
NET COST OF COVERAGE PROVISIONS	1,383

Source: Congressional Budget Office, staff of the Joint Committee on Taxation.

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Health care spending may have slowed

- Price of health care goods and services increased by 0.9% over the past year
  - slowest growth rate in 50 years
    - The Federal Bureau of Economic Analysis

- Total spending for a typical family enrolled in employer coverage increased 5.4% in 2014, down from 6.3% in 2013
  - smallest percentage increase since these data began in 2002
    - Milliman Research Report, May 2014

Health care spending may have slowed

- **Employer premiums:** total premium in the plans for large companies examined by HR services firm Automatic Data Processing grew just 1.7% from 2013 to 2014, compared to 3.1% in previous 12 months

- **Employer health benefit costs**: per hour employer spending on health benefits for private sector workers increased by 2.4%, down from a 3.0% increase over the prior year
  - This is among the slowest growth rates recorded since these data were first collected in 1981.

    The Bureau of Labor Statistics

Health care spending may have slowed

- **Per enrollee spending in private insurance:** increased by just 3.5% over the 12 months ending in November 2013, down from 4.9% over the preceding year.

- Professional services and prescription drugs also rose at a slower rate than the previous year.

Standard and Poor's quarterly report

Medicare Payments linked to efficiency and quality

- Bundled Payments
- Performance-Based Payment
- Hospital Readmissions Reduction Program*
- Accountable Care Organizations*

Hospital Readmissions Reduction Program

- CMS reduced payments to acute care hospitals with excess readmissions
- Initially targets AMI, Heart Failure, and Pneumonia
- Excess readmission ratio
  - Comparison of hospital's risk-adjusted readmission performance to national average
  - Based on 3 years of discharge data with minimum of 25 cases per condition per hospital
- Payment reductions applied to all Medicare admissions if risk-adjusted readmission rate exceeds average

Source: CMS

Hospital Readmissions Reduction Program

- **Analysis of year-1 results**
  - **2,189 (66.7%) will receive payment cuts.**

Percent of Hospitals Highly Penalized	
Large (400+ beds) 40%	Small (<200 beds) 20%
Teaching 44%	Non-Teaching 33%
Safety Net 44%	Non-Safety Net 30%

Source: K.E. Joynt, A.K. Jhan, *JAMA* 2013: 309(4): 342-343

Accountable Care Organizations

- Provider-based organizations (medical groups, hospitals that employ physicians, integrated delivery systems, physician-hospital organizations, and IPAs) that take responsibility for the health care needs of a defined population

Affordable Care Act includes 3 ACO Models

- Medicare Shared Savings Program
  - 218 organizations to date
- Advance Payment ACO
  - 35 organizations participating
- Pioneer ACO Program
  - 23 organizations currently

Medicare Shared Savings Program

- Responsibility for overall costs and quality of care for a population
- Formal legal structure for receiving and distributing payments for shared savings
- Processes to promote evidence-based medicine, reporting on quality/cost metrics, coordination of care
- Capacity to provide care for at least 5,000 Medicare beneficiaries
- 3 year agreement

Advance Payment ACO

- Meant to help smaller ACOs with less access to capital participate in the Shared Savings Program
- Selected participants will receive upfront and monthly payments to make investments in their care coordination infrastructure
- These advance payments will be repaid from the future shared savings they earn

Pioneer ACO

- Designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings
- No longer accepting applications

Year 1 ACO results

- Savings exceeded $380m
- Shared Savings Program
  - Nearly ½ (54 out of 114 that started in 2012) had lower expenditures than projected in 1st 12 months
  - 29 of the 54 generated shared savings over $126m
- Pioneer
  - Gross savings of $147m
  - 9 out of 23 had significantly lower spending growth relative to Medicare FFS while exceeding quality reporting requirements

Source: CMS Press Release 2/30/2014

Effect on Health Care Outcomes

Hospital Acquired Conditions

- Reduction from 154 to 132 per 1,000 discharges in between 2010 and 2012
- Reduced adverse drug events, falls, infections, etc.
  - Estimated 15,000 deaths prevented in hospitals
  - Estimated savings of $3.2 billion in 2012

Source: Health & Human Services report, 5/7/2014

Readmission Rates

- All-cause 30-day Medicare FFS
  - 19-19.5% for 2007-2011
  - 18.5 % in 2012
  - 17.5% in 2013

Source: Health & Human Services report, 5/7/2014

Public Perception

- An Enroll America survey shows largely positive reviews from people who picked up coverage because of the law during its six-month enrollment period.
  - 41% of respondents happy with their coverage; 11% unhappy
  - 74% very or somewhat confident in ability to pay premiums
  - 56% said health plans offered enough physicians & providers; 13% said there were not enough
  - 47% felt "relieved" knowing they were insured

Source: Howell, "Obamacare enrollees happy with coverage: survey," *Washington Times*, 5/27

Public Perception

- 60% of U.S. residents say that neither they nor their families have been affected by the ACA.
  - Negatively: Republicans 37%; Democrats 5%
  - Positively: Democrats 26%; Republicans 8%
- 30% of respondents believed the law helped someone they know obtain coverage
  - Democrats 46%; Republicans 19%
- 23% said they knew someone who had lost their job as a result of the law and 19% reported that they knew someone who faced a reduction in work hours because of the law
  - Republicans 34%; Democrats 15%

Source: "Capsules," *Kaiser Health News*, 5/30

What can we expect?

Going Forward

- HealthCare.gov overhaul as part of an effort to avoid the technical glitches and resulting delays that plagued the initial open enrollment period last fall
  - elimination of some of the website's problematic features
  - addition of new features, including a health plan comparison tool and new cloud-computing management from Amazon's web services unit.

Source: Ante et al., "Administration Overhauls Federal Health-Care Website," *Wall Street Journal*, 6/5

Going Forward

- Beginning in 2011, the ACA required insurers to report and justify premium rate increases exceeding 10%.

- Beginning next year, insurers must report and justify all rate increases.

Concluding Remarks

- The Affordable Care Act will make insurance coverage affordable for millions of uninsured Americans.
- We are likely to encounter several surprises (good and bad) along the way.
- Controlling cost growth is essential for preserving gains in insurance coverage.