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THE AFFORDABLE CARE ACT

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The Affordable Care Act (ACA), commonly referred to as Obamacare, was enacted by Congress in 2010. How has it succeeded? How has it failed? What do we still not know? Can it be improved? The present law is broad and complex with many goals and even more provisions. This paper will deal with its major achievements, its biggest disappointments, questions not yet answered, and suggestions for making needed changes.

SUCCESSES:

According to the Census Bureau, over twenty million more people now have health insurance. Recently, the both the Census Bureau and a Gallop Poll reported that the number of uninsured Americans dropped from 13.3% of the population to 9.1%. (1) Many of these newly insured Americans could not have afforded insurance before the ACA or would have been refused insurance because of a pre-existing health condition. Under the ACA, health insurance is subsidized for those with low and middle incomes. Young people up to age 26 became eligible to remain covered through their parents. In addition, states who opted for government subsidy to expand Medicaid coverage under the ACA, were able to provide health insurance for more people without additional costs.

Studies have found that Americans have become less vulnerable to financial shocks related to health issues. Fewer people could not pay their medical bills or avoided getting medical care because of its cost. Medical debt and bills in collections have definitely declined. Prior to the ACA, a large percentage of bankruptcies were cause by catastrophic medical costs.

The ACA required insurers to provide more comprehensive health coverage. Policies now cover services like maternity care and treatment for drug addiction with no annual cap in payments. Patients have increased access to mental health counseling, contraception, and cancer screenings.

The ACA contains a mix of new spending and taxes, which, along with cuts to the federal Medicare program, should save us more than it costs. The Congressional Budget Office estimates that if the present law continues, it will save federal dollars, thus lowering the federal deficit, through at least 2025. Even with small changes to tax provisions under the law, an analysis by the Committee for a Responsible Federal Budget, ran the numbers and corroborated the Congressional Budget Office findings. (2)

FAILURES:

The insurance marketplaces and Medicaid expansion are a good deal for people near the poverty line. However, for many of those with higher earnings which make them ineligible for subsidies, premiums are high and can cause a financial hardship, and deductibles are often much higher than those seen in typical employer-provided health plans. Many healthy young Americans are paying fines instead of enrolling in the ACA. Without enough younger, more healthy enrollees, the pool opting for the ACA is older, sicker, and less predictable in regard to health care needs. Therefore, insurers say they are forced to raise costs significantly or pull out of the ACA market.

Even though insurance through the ACA is easier to shop for than when it was first enacted, it still remains quite complicated. Selecting the right health plan is often frustrating or, in some cases, impossible for too many Americans who are unsure of their health needs and/or are unable to understand jargon, such as "out-of-pocket maximum" or "in-network provider." Patients, once insured, still often struggle to use their policies and can be hit with surprise bills and long negotiations with their carriers. In addition, in some parts of the United States, enrollees have only one or very limited insurers. The remaining insurance companies have also been shifting around their offerings each year. The number of doctors or hospitals available through their plans are becoming more limited. Therefore, enrollees find it necessary to change health plans, doctors, hospitals, etc. annually in order to find an affordable policy. (2)

QUESTIONS NOT YET ANSWERED:

It would probably take many more years before we can determine if the ACA is making Americans healthier. There is some encouraging, but too early evidence, that low-income people in two states with expanded Medicaid have reported improving overall health compared with neighboring states that declined Medicaid expansion. Research has indicated that more low-income Americans have visited a doctor and received basic preventive health services, including prescription contraceptives and treatments for diabetes. Twenty million people, however, is a small fraction of the nation's population, and it will most likely take years to determine measurable results.

There is no truly definitive evidence that the ACA has been the reason for the slowing of health spending. It is hard to separate the effects of the health law from forces like the great recession, rising insurance deductibles, and a slowdown in the development of new medical technologies. That is another area that would most likely take years to determine.

Did the health law make medical care safer and more evidence-based? Have hospitals improved the quality of care due to the ACA? The law has contained many provisions to improve care received in hospitals. Whereas the health system is still too often a dangerous place for patients, fewer patients are contacting infections in hospitals, and fewer patients are leaving the hospital only to be readmitted within a few weeks. There is not definitive proof that these improvements are directly related to the ACA. Some trends were beginning before the passage of the health care act and, possibly, might have happened anyway. Certainly, requiring safety improvements and more oversight should prove beneficial and bring about continued progress. (2)

SUGGESTIONS FOR FIXING THE AFFORDABLE CARE ACT:

The ACA marketplaces can only be successful if enough insurers participate. We must draw insurers into the markets, keep them there, and limit premium growth. One way that success can be achieved is by subsidizing plans more and by limiting their risk of loss. Medicare+Choice, now Medicare Advantage, in the early years went through similar problems to those being experienced by the ACA. The 2003 Medicare Modernization Act—passed by a Republican Congress and signed by President George W. Bush—drastically increased payments to

plans, and insurers flooded the market. Although members of both parties were concerned that the plans were overpaid and wasting taxpayer resources, by 2007, every Medicare beneficiary had access to at least one plan and the market stabilized, enrollment continued to grow, costs were controlled, and one in three Medicare beneficiaries was enrolled in a private plan. Increasing the subsidization of the ACA plans similarly, might reduce costs to patients and bring in both more consumers and insurers. (3)

Part D, the Medicare prescription drug program, also runs entirely through private plans. Large losses are cushioned by a risk corridor program, which allows plans to stay in the market if they miscalculated the needs of the patients they attracted. The program allows them to keep premiums lower because they do not need to hedge against the full cost of potential losses. The ACA included a risk management program and a risk corridor program for marketplace plans. However, the risk corridor program expired at the end of 2016, along with a reinsurance program that compensated insurers for unusually high-cost patients. If Congress follows the model of Part D and makes the risk corridor program and the reinsurance program permanent, it could help stabilize the market places. (4)

Summary of Risk and Market Stabilization Programs in the ACA (4)

	Risk Adjustment	**Reinsurance**	**Risk Corridors**
What the program does	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Provides payment to plans that enroll higher-cost individuals	Limits losses and gains beyond an allowable range
Why it was enacted	Protects against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets	Protects against premium increases in the individual market by offsetting the expenses of high-cost individuals	Stabilizes premiums and protects against inaccurate premium setting during initial years of the reform
Who participates	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges	All health insurance issuers and self-insured plans contribute funds; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment	Qualified Health Plans (QHPs), which are plans qualified to be offered on a health insurance marketplace (also called exchange)
How it works	Plans' average actuarial risk will be determined based on enrollees' individual risk scores. Plans with lower actuarial risk will make payments to higher risk plans.	If an enrollee's costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap). Payments net to zero.	HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims. Plans with actual claims less than 97%

	Payments net to zero.					of target amounts pay into the program and plans with claims greater than 103% of target amounts receive funds.
When it goes into effect	2014, onward	(Permanent)	2014 – 2016 years)	(Temporary – 3)		Payments net to zero. 2014 – 2016 (Temporary – 3 years)

The original ACA allowed for a public option—a public health insurance plan that would compete with private companies and that would work with the ACA. In fact, the non-partisan Congressional Budget Office concluded in 2013 that a "public option" would reduce the federal budget deficit by $158 billion through 2023. The option, however, was removed from the ACA to get private companies on board.

Putting a public option back in the ACA could fix the program by offering more options to consumers and would possibly bring down the cost of the insurance. The only real stipulation would be to make sure that the public option does not affect what private insurers offer but is attractive enough to compete with them.

There are two types of public options:

1. Weak options that just cover low income citizens or certain groups in certain areas.
2. Strong options that would roll in other subsidy programs, like Medicaid and Medicare. They could also include aspects of a voucher system and could replace a lot of the bureaucracy of assistance programs. They could also be structured to keep them attractive to businesses and upper income consumers. (1)

Another suggestion would be to require insurers to participate in broad regions. This "fix" would limit the private insurers from selectively working in more profitable areas and shunning others like rural areas. (5)

Expanding Medicaid has been working well in states that have opted for this coverage. Expanding it throughout the country might prove beneficial. (6)

There have been suggestions to lower the age of enrollment in Medicare to 55. This change would remove the older, possibly sicker people from the ACA. Insurers would carry less risk and costs would go down. This suggestion might reduce the number of enrollees in the ACA; however, it might help stabilize Medicare. (5)

Finally, the penalty for eschewing coverage by the ACA is so low that many people are paying the fine instead of enrolling in the federal health care program. Again, copying Medicare's policy which not only includes significant penalties, but grows those penalties the longer one waits to enroll for coverage, might encourage early enrollment. (5)

CONCLUSION:

Americans have made it clear that they do not want to give up their health insurance. Republicans might gain a great deal of support if they followed actions taken by the Republican Congress and President George W. Bush in 2003 to fix problems with Medicare, and work with Democrats to fix problems with the Affordable Care Act, and in doing so make America proud while lowering the deficit and the overall exorbitant cost of health care in the United States.

(1) May 15,2017, Money, What is the Public Option for Health Insurance, Alicia Adamczyk
(2) February 5 2017, The New York Times, Grading Obamacare, Successes, Failures and Incompletes, Margaret Sanger-Katz
(3) November 14, 2016, The New York Times, Politics Aside, We Know How to Fix Obamacare, Austin Frakt
(4) August 17, 2016m Kaiser Family Foundation, Explaining Health Care Reform, Risk Adjustment, Reassurance and Risk Corridors, Cynthia Cox, Ashby Semonskee, Gary Clastor and Larry Levitt
(5) October 26, 2016, The New Yorker, Three Ways to Fix Obamacare, John Cassidy
(6) March 30, 2017, Brookings Institution, Want to Fix Obamacare, Henry J. Aaron