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The Future of the Affordable Care Act and Insurance Coverage

We describe the patterns of coverage gains associated with the Affordable Care Act (ACA) expansions and use these patterns to assess the potential impact of alternative repeal or repeal and replace strategies because Congress and the president are weighing options to repeal or replace the ACA.

We find that specific provisions of the ACA, including the Medicaid expansion and the structure of premium subsidies, have been associated with large and robust gains in insurance coverage. We evaluate the impact of retaining dependent coverage and high-risk pool provisions and show, on the basis of the ACA experience, that these provisions would have little effect on coverage.

We find that many replacement proposal components, including flat tax credits and maintaining cost savings provisions, could jeopardize the ability of many of the ACA's primary beneficiaries, as well as other Americans, to access coverage and care. By leading to a deterioration of the safety net, these strategies could also imperil population health activities. (*Am J Public Health.* 2017; 107:538–540. doi:10.2105/AJPH.2017.303665)

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The Republican administration intends to repeal the Affordable Care Act (ACA; Patient Protection and Affordable Care Act, Pub L No. 111-148, 124 Stat. 855 [March 2010]) and replace it with an alternative. Such a change could have substantial effects on coverage and access to care and on the public health system. The simplest repeal of the ACA would undo it entirely and return health insurance coverage more or less to where it was before the ACA's passage, when 16% of Americans were uninsured.[1] Some critics of the law have proposed replacements that retain some popular provisions.[2] The effects of such a partial repeal depend on the details. We use what has been learned from the experience of the ACA expansions to assess the potential impact of alternative repeal and replace strategies.

LEARNING FROM THE AFFORDABLE CARE ACT EXPERIENCE

Several coverage-related provisions of the ACA took effect almost immediately upon passage. These provisions have continuing bipartisan support—unfortunately, they had modest impacts. One provision mandated that young adults be made eligible for coverage on their parents' employer-sponsored health plans. This extension of eligibility expanded insurance coverage by between one and three million people. Another provision created a temporary program of high-risk pools—the Pre-existing Condition Insurance Plan—which offered subsidized coverage to those with serious chronic health conditions. It ultimately enrolled some 130 000 people, albeit at a very high cost per person. The limited effect of the Pre-existing Condition Insurance Plan on coverage mirrored previous experience with similar high-risk pools, which had existed in 34 states: they were difficult and costly to operate and ultimately enrolled only about 200 000 people nationwide.[3]

These early implemented provisions had limited impact on the national insurance coverage rate. Before the ACA's broad subsidized coverage options—the focus of the current Republican attack—became available, the US uninsurance rate stood at 14.4%, and among nonelderly adults more than one in five were uninsured.[1] Beginning in January 2014, the ACA's new, subsidized coverage options became available. Households are eligible for tax credits for private insurance proportional to the gap between their income and the price of health insurance coverage in their community.[4] The subsidies are designed to encourage households to choose lower cost plans among those available to them. At the same time, lower income households are protected against premium increases that affect the entire marketplace. As community-level health insurance premiums rise, subsidies rise along with them. This subsidy design ensures that increases in premiums do not give participants an incentive to drop their health insurance altogether.

The subsidies and related spending represent a substantial federal commitment—$43 billion in 2016—to helping middle-income Americans afford coverage. New subsidies were accompanied by new regulations in the private insurance market. Coverage sold in the nongroup market must be available to all, regardless of health status; may not be underwritten, that is, the price of the plan may not change to reflect preexisting health insurance conditions; may not vary in price between men and women; and may vary in price with age only by a factor of three.

Finally, the ACA, as modified by the US Supreme Court in its

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This article was accepted January 10, 2017.

doi: 10.2105/AJPH.2017.303665

decision in *NFIB v. Sebelius*,[5] allowed (but did not require) states to expand their Medicaid programs to include all documented residents with incomes below 138% of the federal poverty level, with most of the cost borne by the federal government. As of October 2016, 31 states and Washington, DC, have taken advantage of this opportunity, at a federal cost of $74 billion in 2016.[6]

The ACA overall reduced the federal deficit. Although the coverage expansions generate net costs, the combined costs of the expansions are more than fully offset by reductions in federal payments to hospitals and other providers as well as by new revenue provisions. Reductions in provider payments were justified on two grounds. First, some provider payments, such as Medicare disproportionate share payments, are intended to compensate providers for the cost of treating patients who cannot pay their bills. The ACA's expansions of Medicaid were expected to reduce the need for such payments, and subsequent research has shown that uncompensated care costs declined significantly in states that chose to expand their Medicaid programs.[7] Second, the increase in insurance coverage was expected to lead to greater use of health services. For many health care providers, additional revenue generates higher net earnings. Consistent with these expectations, health care spending accelerated after implementation of the ACA expansions.[8] Despite the ACA's reductions in payment rates, hospital operating margins increased after implementation of the expansions.[9]

The effect of the coverage expansion provisions was dramatic. By the spring of 2016, the overall US uninsurance rate had fallen to 8.9%, the lowest level since the Centers for Disease Control and Prevention began collecting data in 1972.[10] More detailed state-by-state estimates of coverage effects among nonelderly adults from 2011 to 2015 can be derived from the Behavioral Risk Factor Surveillance System (BRFSS), which collects data on more than 400 000 adults a year and has used consistent questions on health insurance throughout this period. According to the BRFSS, the national uninsured rate among nonelderly adults fell by nearly seven percentage points with the rollout of coverage, from an average of 21.6% during the 2011 to 2013 period to 14.7% in 2015. As Exhibits A through C (available as a supplement to the online version of this article at http://www.ajph.org) show, with the introduction of the ACA, the uninsured rate fell in every state. In 2011 to 2013, only 11 states had uninsured rates below 15%; by 2015, 35 states had uninsured rates below 15%. Uninsured rates also fell in Massachusetts and in Hawaii, states that had undertaken ambitious state-specific reform efforts before the ACA.

Gains were greatest in states that chose to adopt the Medicaid expansion. In states that adopted the expansion, rates fell, on average, from 18.9% to 11.6%, (a 7.3% decline), whereas in those that did not, rates fell from 25.6% to 19.2% (a 6.4% decline). Nonetheless, substantial reductions in uninsured rates were achieved even in states that have not yet participated in the Medicaid expansions. For example, the 27.2% uninsured rate among nonelderly adults in Texas in 2015 was 6.7 percentage points lower than that state's rate in 2011 to 2013.

Uninsurance rates fell in all race/ethnicity groups—particularly sharply among Blacks, especially in states that expanded Medicaid. Yet, the majority of people who gained insurance coverage through the law have been non-Hispanic Whites. The largest absolute gains in coverage were among those with the lowest incomes, especially in states that had expanded Medicaid (Exhibit D, available as a supplement to the online version of this article at http://www.ajph.org). Nonetheless, higher income groups also saw reductions in uninsurance. About 600 000 people with incomes above $50 000 gained coverage between 2011 to 2013 and 2015.

The pattern of coverage gains points to the importance of the ACA's subsidies, rather than its insurance reforms, in contributing to increases in coverage. For example, in percentage terms, coverage gains have been comparable across all age groups: both among older adults—who benefited from the elimination of underwriting, the age bands, and the elimination of preexisting condition restrictions—and among younger adults—who largely did not (Exhibit E, available as a supplement to the online version of this article at http://www.ajph.org). Because the initial uninsurance rate was much higher among young adults, about 1.5 times as many young adults aged 25 to 34 years gained coverage through the expansions as did older adults aged 55 to 64 years. Similarly, the BRFSS data since 2011 does not show any substantial change in the composition of the uninsured in terms of general health status (Exhibit F, available as a supplement to the online version of this article at http://www.ajph.org).

The 2014 expansions were much more effective in expanding coverage than were the more modest steps taken in 2011. Notably, just as many of those aged 18 to 24 years gained coverage through the later expansions as had through the earlier dependent coverage provisions—those gaining coverage later were more likely to be from low-income families in which the parents themselves did not have stable employer-sponsored coverage. Five times as many people who self-reported poor health gained coverage through the expansions of 2014 as the total number who had been covered under the earlier Pre-existing Condition Insurance Pools. These patterns are consistent with the observation that the primary reason given by people who lacked coverage before the ACA was that coverage was simply too expensive.

IMPLICATIONS FOR ALTERNATIVE REFORM PROPOSALS

The ACA generated large, widespread coverage gains. If the entire act were repealed, these coverage gains would disappear, and the share of the US population lacking insurance coverage, which had increased steadily from 2001 through 2011, would resume its upward climb.

Several of the early expansion provisions—allowing young adults to remain on their parents' health insurance and creating a system of high-risk pools—are included in many Republican replacement proposals.[11,12] Evidence from the ACA

experience shows that retaining these early expansion provisions while eliminating the subsidies and Medicaid expansions would counterbalance only about 10% of the precipitous drop in coverage generated by full repeal.

In addition to the early expansion components, many ACA replacement proposals would retain the restrictions against insurers' charging higher premiums to sicker people, while eliminating or changing the nature of the premium tax credits and Medicaid expansion. For example, some proposals offer flat tax credits adjusted only for age, which increase only at a predefined rate regardless of community-wide premium growth.[12] These scenarios could leave many Americans worse off than they had been before the ACA was passed.

In insurance markets that do not price on the basis of health status, healthy consumers seek to segregate themselves from sicker people, and insurers respond by offering ever skimpier coverage to the healthy and ever higher premiums to the sick. This is not just a theoretical expectation. Before the ACA, several states had imposed regulations restricting underwriting and preexisting condition restrictions in their nongroup markets. The consequent selection spirals ultimately undermined entire state insurance markets. The ACA subsidies, in their design, counterbalance this effect, encouraging healthy consumers to buy coverage alongside sicker consumers and protecting against selection spirals even when premiums rise. Without subsidies that protect consumers against community-wide premium growth, a ban on preexisting condition restrictions and health-based underwriting could readily destroy nongroup insurance markets.

Similarly, many plans propose to replace the ACA's Medicaid expansion with either per capita allotments or block grants of unspecified size.[11] Previous analyses of a block grant alternative to the Medicaid expansion predicted massive state-level rollbacks in Medicaid coverage that would leave very large numbers of poor people without insurance coverage.[13]

The worst repeal scenario would eliminate subsidies and retain the act's reductions in payments to hospitals and other providers. This scenario could be accomplished through the budget reconciliation process, which requires only 51 votes to pass the Senate. Recall that providers accepted the existing payment reductions in return for the combination of reduced uncompensated care costs and higher expected revenue from newly insured patients. Hospitals' experience since 2014 suggests that this tradeoff—lower payments in exchange for higher paid volume—was justified, and the gains were realized. If the Medicaid expansions were to be repealed, these providers would face an even greater burden of uncompensated care. If the subsidies were repealed, providers would face losses in revenue from substantial declines in the number of insured patients. Both of these forces would exacerbate the effects of the continuing payment cuts.

CONCLUSIONS

Our analyses of the gains in coverage achieved through implementation of the ACA's coverage expansions, like other models, clearly indicate that repealing the ACA would lead many millions of Americans to lose their health insurance coverage.[13] Most advocates of repeal promise to replace the ACA with an alternative health reform design. The ACA is by no means perfect, and alternative designs might well generate improvements—but the effects will depend critically on the details.

The ACA experience shows that young adult provisions and high-risk pools would together do very little to restore coverage. Replacing the ACA's subsidies with flat tax credits, while retaining the popular insurance rating provisions, could lead to the collapse of health insurance markets. Eliminating coverage expansions while retaining provider payment cuts could devastate the health care safety net. The combination of reduced coverage and a diminished safety net would put new pressures on public health departments. Rather than emphasizing population health, they would once again become providers of last resort. Those concerned with public health and with access to preventive, curative, and palliative care for vulnerable populations should monitor proposed designs very carefully. AJPH

CONTRIBUTORS

S. Glied wrote the article and designed the study. A. Jackson analyzed the data and contributed to the writing of the article.

ACKNOWLEDGMENTS

We thank the Commonwealth Fund for providing research support for this commentary (grant 2016-0691).

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