Update on the Impact of the Affordable Care Act on Consumers

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Background

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), or more informally Obamacare, was signed into law by President Obama on March 3, 2010.

The Act was designed to be phased in over a number of years, and its goals are to expand coverage and add consumer protections, control healthcare costs, and improve the healthcare delivery system.

The first provisions of the Affordable Care Act were implemented in 2010 and focused primarily on coverage expansion and consumer protections. These included provisions that allow young adults to stay on their parents' policies until they turn 26; implementation of temporary insurance programs for people with preexisting conditions and for early retirees; provision of federal matching funds to states to cover some additional low-income individuals and families under Medicaid; and institution of new insurance rules, such as banning plans from rescinding coverage when a beneficiary gets sick and banning lifetime caps on coverage.

In 2011, limits on nonmedical or administrative spending by health plans kicked in. Under this provision, known as the Medical Loss Ratio or MLR, health plans in the large-group market must spend 85% or more of their premiums on medical care; for the small-group market, the figure is 80%. Plans that fail to meet this MLR requirement must offer rebates to their enrollees. Other 2011 provisions include "donut hole" discounts, a pharmaceutical manufacturer fee, and restrictions of over-the-counter drug reimbursement to those drugs prescribed by a doctor.

In 2012, several programs focused on quality and cost containment were initiated, including the Medicare Shared Savings Program, establishing accountable care organizations (ACOs), a Medicare hospital preventable readmission program, and a hospital value-based purchasing program. 2013 provisions included flexible spending limits and some new Medicare taxes.

The state-based and federally facilitated health insurance Marketplaces went live on October 1, 2013, allowing people to compare participating plans online and to sign up for insurance with coverage starting on January 1, 2014. As of August 28, 2014, there were 17 state-based Marketplaces (SBMs), 17 federally facilitated Marketplaces, and 7 partnership Marketplaces. In this paper we refer to both federally facilitated and partnership Marketplaces as FFMs. The difference between them is that the latter may administer plan management functions, in-person consumer assistance functions, or both, and HHS will perform the remaining Marketplace functions.[1]

Although the roll-out of the FFM website, healthcare.gov, was seriously flawed and deterred some people from signing up initially, by the end of open enrollment (including the Special Election Period) on April 14, 2014, there had been almost 100 million website visits and 33 million calls to the call centers.[2]

A full listing of the ACA provisions through 2018 can be found in **Table 1**.

The remainder of this article will summarize the current status of the coverage expansion and consumer protection provisions.

Enrollment

The total number of people insured under the various provisions of the ACA is about 14 million.[3] This includes approximately 8 million who signed up via the SBMs and the FFMs, 3 million young adults who were able to stay on their parents' plans until age 26, and 3 million people newly covered because of Medicaid/Children's Health Insurance Program (CHIP) expansion.

According to a detailed enrollment report published by HHS in May 2014,[2] more than 8 million Americans enrolled via an SBM or FFM during the open enrollment period (October 1, 2013, to

March 31, 2014); people who qualified for the Special Enrollment Period (SEP) enrolled through April 19, 2014. It is important to note that the report included people who had signed up, but might not have yet paid their first premium.

The demographic breakdown is as follows:

- 54% female, 46% male
- 2.2 million (28%) are between the ages 18 of 34 years
- 2.7 million (34%) are between the ages of 0 and 34 years

Impact on the Uninsured

The results of formal federal surveys measuring the impact of 2013 open enrollment (for 2014 coverage), such as those of the US Census Bureau and the National Center for Health Statistics, won't be available until later this year, with the estimated date of release being fall 2015. Researchers have therefore turned to "rapid-turn-around" data sources such as the Gallup-Healthways Well-Being Index (WBI) and the Kaiser Family Foundation surveys.

A Kaiser Family Foundation survey published in June 2014 found that 57% of the 8 million people who enrolled in a Marketplace plan were previously uninsured.[4] Seven in 10 of those who were uninsured prior to purchasing a Marketplace plan said they decided to purchase insurance because of the law; most had been uninsured for 2 years or more.

Researchers led by Benjamin Sommers, MD, PhD, assistant professor of health policy and economics at the Harvard School of Public Health in Boston, Massachusetts, reported the results of their analysis of the Gallup-Healthways WBI surveys in a Special Report in the August 28, 2014, issue of the *New England Journal of Medicine*.[5] They used survey data for January 1, 2012, to June 30, 2014. This means that the increases in the number of insured people related to extending coverage for young adults on their parents' policies to age 26 years, implemented in 2010, had largely already been incorporated into the baseline. Also, the survey sample included only people aged between 18 and 64 years, so increases related to newly insured children were also not counted, nor were individuals who enrolled in Medicaid due to some early Medicaid expansions in 2010 and 2011. Because open enrollment via the Marketplaces began in October 2013, the study compares increases in the percentage of insured individuals pre- and post open enrollment.

Here is what they found:

- Compared with the baseline of about 20% to 21%, the uninsured rate declined by 5.2 percentage points ($P = .001$) between September 2013 and April 2014—a 26% decline.
- For individuals with incomes ≤138% of the federal poverty level, there was a statistically significant decline in the uninsured rate of 6 percentage points ($P = .006$) in the states that expanded Medicaid compared with a non-significant decline of 3.1 percentage points ($P = .13$) in states that did not.
- When directly comparing low-income adults in states with expansion versus those without, Medicaid expansion was associated with a reduction in uninsured of 5.1 percentage points ($P = .01$).
- People with incomes between 139% and 400% of the federal poverty level were eligible for subsidies even in states that didn't expand Medicaid. In the Medicaid expansion states, uninsured rates among these individuals dropped by 9 percentage points and in the non-expansion states by 5.5 points ($P = .01$ for both comparisons).

Having insurance, of course, is only part of the story. The 2 access to care measures included in the survey both showed the changes you might expect with an expansion of insurance coverage:

- A 2.2% increase in the number of people stating they have a personal doctor ($P = .001$).
- A 2.7% decrease in those stating they couldn't afford medical care ($P = .001$).

Satisfaction

As noted above, results of federal surveys are not yet available, but a survey conducted by the Commonwealth Fund and published in July 2014[6] reported that:

- 81% of people with new Marketplace or Medicaid coverage are optimistic that it will improve their ability to get the care they need.
- More than half (58%) said they are better off now than they were before enrolling in their new insurance plan.
- By June 2014, 6 of 10 adults with new Marketplace or Medicaid coverage said they had already used their insurance to go to a doctor or hospital or to fill a prescription.
- A majority (62%) said they would not have been able to access or afford this care before enrolling.
- 54% of adults with new coverage said their plan included all or some of the doctors they wanted.
- 68% said they were able to get an appointment with a PCP within 1 to 2 weeks; 58% were able to get a specialist appointment within that time frame.
- One of 5 adults with new coverage tried to find a new primary care physician; three-fourths found it very or somewhat easy to do so.

COVERAGE

The Essential Health Benefits

Individual and small-group plans, offered both inside and outside of the Marketplaces, must now offer a set of defined Essential Health Benefits (EHBs). These benefits must be offered for the plan to be certified as a qualified health plan and offered in the Marketplaces. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid. There can be no annual or lifetime coverage caps on these benefits.

The EHBs include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services including behavioral health treatment
- Prescription drugs

- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Plans must offer EHBs, but may add additional benefits and services.

Preventive Services

Preventive services, provided by a network provider, cannot be subject to co-payments, co-insurance, or deductibles. Examples of such services for adults include screenings for blood pressure, cholesterol, colorectal cancer, and depression; alcohol misuse screening and counseling; and a variety of age-appropriate vaccinations.

Services for women include cervical cancer screening, domestic violence screening and counseling, and breast cancer-screening mammograms for women over 40 years of age. It also includes FDA-approved contraception with no cost sharing, a benefit that is estimated to have reduced out-of-pocket costs by $483.3 million, comparing 2013 with 2012.*

Preventive services for children include hearing screening for newborns, age-appropriate vaccinations, autism screening at ages 18 and 24 months, and depression screening for adolescents.

A complete listing of preventive services can be found at https://www.healthcare.gov/what-are-my-preventive-care-benefits.

Approximately 76 million Americans became newly eligible for expanded preventive services because of the ACA.[7]

The "Metal Levels"

Marketplace plans offer tiered coverage, called the "metal levels." They vary by premium and out-of-pocket (OOP) costs. Bronze plans have the lowest monthly premiums, highest OOP, and cover on average about 60% of the total cost of a covered benefit. The Silver level plans cover 70%; Gold, 80%; and Platinum, 90%. All plans offer the same set of EHBs. Catastrophic plans are available via the Marketplaces, but only for young people and people with hardship exemptions.

Most people (65%) who enrolled in a Marketplace plan during the first open enrollment chose the Silver plan. Twenty percent chose the Bronze plan, 9% the Gold, and 5% Platinum.[2] Only 2% selected a Catastrophic plan.[2]

Subsidies

Eligibility for a subsidy depends on household size, age, and income and is influenced by where you live. An online subsidy calculator can be found at http://kff.org/interactive/subsidy-calculator. In 2014 the eligibility level was between $11,490 and $45,960 for individuals, and between $23,550 and $94,200 for a family of 4. Premium tax credits, payable in advance (Advance Premium Tax Credits, or APTCs) were applied directly to the monthly premium to help lower its cost. Eligible individuals paid 2% to 9.5% of their income, on a sliding scale, and the federal government covered the difference between that and the cost of the second-lowest-cost Silver plan (also called the Benchmark plan).[8]

Some individuals, earning between 100% to 250% of the FPL, also qualified for out-of-pocket cost-sharing reductions, but this option only applied to Silver plans.

Of those who enrolled during the first open enrollment period, 85% selected a plan with financial assistance.[2] The Congressional Budget Office (CBO) estimates the gross costs of the subsidies and related spending for insurance obtained through the Marketplaces, Medicaid, CHIP, and tax credits for small employers for 2014 to be $1839 billion.[9]

On the same day in July 2014, opposing rulings were made by 2 separate courts about whether subsidies offered via the federally facilitated Marketplaces were legal or not. The language of the ACA, written before it was known that most states would offer the Marketplaces via the FFM instead of their own state-based Marketplaces, maintains that the subsidies are for consumers who bought insurance on an exchange "established by the state." Based on a strict interpretation of this language, one of the 2 courts, the US Court of Appeals for the District of Columbia Circuit, deemed by a 2:1 ruling of a panel of 3 judges that it was illegal to subsidize plans purchased on FFMs. This court recently vacated that decision and has agreed to reconsider the case with a full roster of judges participating.[10]

Medicaid Expansion

One of the coverage expansion strategies of the Act was to expand Medicaid to all non-Medicare eligible individuals under age 65 years (children, pregnant women, parents, and adults without dependent children) with incomes up to 138% of the federal poverty level (FPL). (While the new minimum eligibility threshold is 133% of the FPL, FPL disregard of 5% is included to represent the uppermost limit at which an individual may be eligible for Medicaid). Newly eligible Medicaid recipients will be guaranteed the same essential health benefits that are available through the Exchanges. To finance the coverage for the newly eligible under the Act, the federal government provides 100% of the funding for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% for 2020 and subsequent years. Newly eligible Medicaid recipients will be guaranteed the same essential health benefits that are available through the Exchanges.

In 2012, the Supreme Court ruled that the ACA was constitutional, but it limited the ability of HHS to enforce the Medicaid expansion by withholding matching funds for existing Medicaid programs, essentially allowing states to opt out of the Medicaid expansion. There is no deadline for states to implement the Medicaid expansion under the ACA, and the state-by-state decision-making

**Certain religious employers are exempt from this requirement with respect to certain contraceptive services. In addition, an accommodation is available to certain other non-profit organizations with religious objections to contraception coverage. Details available in the Federal Register (45 CFR 147.31)*

Table 1. Timeline for Insurance Coverage Provisions of the ACA

The Commonwealth Fund's Health Reform Resource Center. http://www.commonwealthfund.org/interactives-and-data/health-reform-resource-center. Accessed September 6, 2014.

2010	2011	2012	2013	2014	2018
• Children up to age 26 years can stay on their parents' healthcare policies • Small businesses (<25 employees, wages <$50K/year) that contribute at least 50% of premium will be eligible for tax credits • Temporary preexisting condition insurance until healthcare Marketplaces go live in 2014 • Temporary reinsurance program for employers providing early retiree benefits • New insurance rules that ban rescinding coverage when people get sick and that ban lifetime caps on coverage. Annual limits on benefits to be phased out by 2014 • Children with preexisting conditions cannot be denied coverage • $250 rebates to beneficiaries hit with the Medicare "donut hole" • All new groups and individual health plans must provide free preventive care for certain services; Medicare will provide this coverage starting in 2011 • Health insurers must submit justifications for "unreasonable" premium increases to federal and state governments, and must report share of premium spent on medical costs	• Medical loss ratio: Rebates must be offered to beneficiaries if <85% of premium (large group plans) or <80% (individual and small group plans) is spent on medical care • Medicare beneficiaries in the Part D "donut hole" receive 50% discounts on brand name drugs; donut hole is closed by 2020 • Voluntary long-term care insurance program is established • Over-the-counter drugs not prescribed by a physician will not be reimbursable through flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs), or tax-free in health savings accounts (HSAs) • Employers must disclose the value of benefits provided on employees' W-2 forms	• Accountable Care, hospital readmission, and hospital value-based purchasing programs are all launched	• First open enrollment via the state- and federally facilitated marketplaces • Contributions to FSAs limited to $2500 per year; coverage to start January 1, 2014 • Expansion of Medicaid preventive services option; if offered without cost sharing, states will receive an increased federal contribution	• All health plans, inside and outside the Marketplaces, must offer a standard benefit package (Essential Health Benefits) • Consumers can purchase tiered plans in the Marketplaces (Bronze, Silver, Gold, Platinum, and catastrophic) with different levels of premium and cost sharing • Insurers will pay an annual fee to help pay for reform • Insurers cannot restrict coverage or base premiums on health status or gender • Premium and cost-sharing subsidies available for families if plans are bought through the Marketplaces • The individual mandate kicks in; the employer mandate (Employer Shared Responsibility provision) was supposed to kick in, but was delayed to 2016 for small employers. Large employers will be subject to the mandate starting in 2015 • In states that chose this option, Medicaid eligibility was expanded to all legal residents with incomes up to 138% of the federal poverty level	• High-cost insurance plans (premiums >$10,200 for individual and >$27,500 for families) will have a 40% excise tax levied on them

process continues to be largely political.

As of the end of August 2014:

- 27 states plus the District of Columbia were expanding Medicaid coverage
- 3 states were considering Medicaid expansion
- 20 states were not currently considering Medicaid expansion.[11] These states represent more than 4 million eligible individuals.[12]
- 1 million people were able to enroll via the "early option" Medicaid expansion in 6 states (California, Colorado, Connecticut, Minnesota, New Jersey, Washington) and the District of Columbia, and another 6 million enrolled in Medicaid or CHIP during the 2014 open enrollment period (October 1, 2013, through March 31, 2014, and until April 19, 2014, under special enrollment).

PENALTIES

The Individual Mandate

The ACA requires all legal residents of the United States to obtain health insurance coverage or pay a fine. The penalty is either a flat dollar amount or a percentage of a household's adjusted gross income in excess of the threshold for mandatory tax filing, whichever is greater. The size of the penalty increases over time, with the flat fine for an individual being only $95 in 2014, but rising to $695 by 2016.[13] The percent of household income starts at 1% in 2014 and increases to 2.5% by 2016. Penalties for children are half that of adults and there is an overall cap on family payments.

The CBO estimates that 23 million of the 30 million people still uninsured by 2016 will be exempt from the penalty because they are unauthorized immigrants; are incarcerated; belong to an Indian tribe; have income below that required to file income tax; or are eligible for Medicaid under the new rules that expanded Medicaid, but live in a state that opted out of expansion.[13] People whose premium exceeds a specified share of their income (8% in 2014) will also be exempt. The report further estimates that only 4 million of the remaining 7 million will actually pay a penalty, resulting in $4 billion being collected in 2016.

Employer Requirements

The ACA includes an Employer Shared Responsibility provision that will start in 2015. Employers with at least 50 full-time employees (average 30 hours of service/week) that do not provide coverage for at least 95% of employees and their dependents will pay $2000 per full-time employee, excluding the first 30 employees. If the employer provides coverage for more than 95% of its full-time employees and dependents, but has 1 or more full-time employees receiving a premium tax credit, then the amount of the payment for each month equals the number of full-time employees who receive a premium tax credit for that month multiplied by

Table 2. Monthly Silver Premiums for a 40-Year-Old Nonsmoker Earning $30,000 Annually
Adapted from Cox C, Levitt L, Claxton G, et al. Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces. Kaiser Family Foundation Issue Brief. September 2014.

State	Rating Area (Major City)	Second Lowest Silver Before Tax Credit			Second Lowest Silver After Tax Credit		
		2014	2015	%Change from 2014	2014	2015	% Change from 2014
California	15 (Los Angeles)	$255	$257	0.8%	$209	$208	-0.8%
Colorado	3 (Denver)	$250	$211	-15.6%	$209	$208	-0.8%
Connecticut	2 (Hartford)	$328	$313	-4.7%	$209	$208	-0.8%
DC	1 (Washington)	$242	$247	2.0%	$209	$208	-0.8%
Maine	1 (Portland)	$295	$282	-4.4%	$209	$208	-0.8%
Maryland	1 (Baltimore)	$228	$235	3.0%	$209	$208	-0.8%
Michigan	1 (Detroit)	$224	$230	2.5%	$209	$208	-0.8%
Nevada	1 (Las Vegas)	$238	$242	1.7%	$209	$208	-0.8%
New York	4 (New York City)	$365	$363	-0.7%	$209	$208	-0.8%
Ohio	11 (Cleveland)	$249	$247	-0.7%	$209	$208	3.3%
Oregon	1 (Portland)	$201	$213	6.0%	$201	$208	-0.8%
Rhode Island	1 (Providence)	$293	$260	-11.4%	$209	$208	3.3%
Tennessee	4 (Nashville)	$188	$205	8.7%	$188	$205	-0.8%
Vermont[a]	1 (Burlington)	$413	$440	6.6%	$209	$208	8.7%
Virgina	7 (Richmond)	$253	$260	2.7%	$209	$208	-0.8%
Washington	1 (Seattle)	$281	$254	-9.8%	$209	$208	-0.8%
Average % change from 2014				-0.8%			0.1%

Source: Kaiser Family Foundation.
[a]Vermont rates do not reflect modifications from the state's review. Filings in CA, CO, CT, MD, MI, OH, OR, RI, TN, and most of WA are final; other states' fillings are still preliminary and may change. Premium changes are at the rating area level.

1/12 of $3000. The monthly payment is capped at the number of the employer's full-time employees for that month (minus up to 30) multiplied by 1/12 of $2000. The cap intended to ensure that the payment does not exceed the payment that employer would owe if it did not offer coverage.[14]

Originally slated to become effective January 1, 2014, the White House decided in mid-2013 to delay this provision until 2015 as a result of employer concerns over implementation and reporting challenges.

This provision raised concerns about an unintended but possible consequence: that employers might try to avoid the penalties by reducing the working hours of their full-time employees. While we will not know the full impact of this provision until it is implemented next year, we have not seen employers taking this step proactively. According to the Bureau of Labor Statistics, as of the end of Q1 2014, the number of part-time workers in the United States had fallen by a total of 300,000 since March 2010, when the Affordable Care Act was passed into law. In the year leading up to the anticipated implementation of penalties, full-time employment grew by over 2 million while part-time employment declined by 230,000.[15]

Premium Prices for 2015

On September 8, 2014, the Kaiser Family Foundation released a report analyzing premium changes for the Marketplace plans for the District of Columbia and the 15 states for which it was able to find 2015 rate data.[8] The foundation compared the rates for the second-lowest cost Silver plan (before tax credit) available in a rating area that included a major city for each state. Across all of the 16 rating areas, before tax credits, rates appear to be decreasing by an overall average of –0.8%.

Because of the way tax credits are calculated, premiums after tax credit in all but 2 cities were also –0.8%. Tennessee (Nashville) had an 8.7% increase and Oregon (Portland), 3.3%, but premiums in those 2 rating areas were so low in 2014 that a single 40-year-old with an income of $30,000 was not eligible for a tax credit (**Table 2**).

Because subsidies are based on the premium for the benchmark plan in a rating area (the second-to-lowest-cost Silver plan), enrollees could face significant premium increases in 2015 if they fail to switch out of plans whose premiums are no longer at or below the level of the benchmark.

Firmer conclusions about 2015 premium prices await more information on rates from the remaining rating areas.

CONCLUSIONS

What We Know

While some statistics are available on the extent to which the Affordable Care Act has increased insurance coverage, it is still too soon to draw definitive conclusions regarding its ability to impact cost, quality, and health status. What we know so far is:

- Healthcare reform continues to be viewed through a political lens, although a recent report from the Kaiser Family Foundation shows that it is a second-line issue for registered voters, falling well below their concern about the economy and jobs.[16] For "more enthusiastic voters," health reform was at the bottom of the list of issues about which they were asked.
- Millions of people have signed up for insurance coverage—but the benefits of ACA are felt unevenly across the country.

What We Think We Know

Based on early reports, we can draw some tentative conclusions that still need to be confirmed with more research, and more time and experience under the new law. They include:

- There has been a meaningful reduction in the uninsured population.
- Enrollees are, for the most part, satisfied with their new plans.
- People are beginning to have improved access to healthcare and providers.
- Consumers may not see dramatic increases in Marketplace plan pricing next year.
- Employers have not taken steps to reduce their full-time workforces to avoid coverage penalties under the ACA; it remains to be seen if they will.

What We Need to Watch

With all we know and think we know about the impact of the ACA, we are far from answering the myriad questions about ongoing implementation of this monumental program of health reform. Among the questions whose answers will determine the ultimate success of the ACA are:

- Will expanded coverage result in improved health, lower healthcare costs and appropriate utilization of healthcare services?
- Will more states expand Medicaid?
- Will the same states continue to use the FFM or will they bring up an SBM or will they partner with SBMs that appear to be functioning well, such as California?
- Will newly insured people who were utilizing the ER for primary care now seek care in their PCP's office?
- Will the addition of people into the system lead to changes in the healthcare workforce such as more primary care and physician extenders?
- Will premiums go up or down?
- Will benefit design remain static or will we see an increase (or decrease) in consumer cost-sharing?
- Will narrow networks stay the same, become narrower, or expand?
- Will employers begin downsizing or cutting hours once the coverage penalties kick in?
- How will the mid-term elections and continued court challenges impact the on-going roll-out of the ACA?
- Will other provisions of the ACA, such as the cost-containment and quality improvement programs, have their intended result?

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