Research

Five Years After Passage: The ACA by the Numbers

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The Affordable Care Act (ACA) changed the American health care system in myriad ways. The primary objectives of the ACA were to expand insurance coverage while reducing the cost of insurance, and to rein in the increasing cost of health care. Whether these goals are being achieved and at what cost to the budget and to the healthcare stakeholders are important considerations. Five years after passage of the ACA, this report attempts to synthesize many of the studies and cost estimates which have been produced in order to answer these questions.

Key Take-Aways

The number of uninsured individuals has decreased, but not by as much as the Congressional Budget Office (CBO) originally predicted.[1]

- 15 million: fewer uninsured individuals since 2010
- 35 million: individuals still without insurance
- 12 million: more people enrolled in Medicaid since 2010
- 11 million: individuals have insurance through a state or federal exchange
- 7.7 million: individuals receiving subsidies for coverage through an exchange

The cost of expanded insurance coverage is being felt at the individual, state, and federal level.

- $300: average increase in annual deductibles for ESI from 2010-2014
- $5,730: average annual cap on out-of-pocket expenses for plans purchased through the exchange in 2014; $2,719 more than the average for ESI plans
- $43 billion: projected individual mandate penalties over the next 10 years
- $167 billion: mandate penalties paid by employers over the next 10 years
- $42.6 billion: cost of ACA regulations implemented thus far
- $1.2 trillion: federal cost for ACA coverage provisions over the next 10 years

The growth in total health expenditures has also returned to pre-recession rates, demonstrating no bend in the cost curve.[2]

- $3.15 trillion: national health care expenditures in 2014
- 17.9: percent of GDP spent on health care in 2014

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The Uninsured

There are many varying estimates of the number of uninsured, both now and before passage of the ACA, but reducing this number was inarguably the primary goal of ACA proponents. In the chart below, you can see the estimates for the non-elderly uninsured population from several different sources, both prior to and in 2014. Most of the coverage provisions of the ACA were fully implemented in 2014, including the opening of the health insurance exchanges (where non-group individual and family coverage could be purchased) and the expansion of Medicaid eligibility in 29 states. The average of the estimates places the uninsured rate at 19 percent before 2014 and down to 15 percent in 2014, with an average estimate of 10.6 million fewer people uninsured.

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One thing to note about estimates of the uninsured is that many of these surveys count people as uninsured if they lacked health insurance coverage at any point during the year. This can obviously be an inaccurate count, as this would capture anyone who may change jobs and thus have a gap in coverage, even for just a few weeks. In 2013, the Census Bureau adapted the wording of its question on being uninsured to try and obtain a more accurate count. Additionally, there are many reasons why it is difficult to know how many individuals are *newly* insured; changes in the Census methodology, general economic growth and unemployment rates, and natural evolution in the health insurance market would all contribute to changes in the number of uninsured, regardless of the ACA's existence. While the Department of Health and Human Services (HHS) claims 16.4 million non-elderly adults have gained coverage since passage of the ACA, it is difficult to know how many of those individuals would have gained coverage anyway.[3]

Further, the ACA has led to multiple coverage gaps which are leaving subsets of the population without any options to purchase affordable health insurance. These coverage gaps result from the complex web of provisions included in the law not fitting squarely with other provisions of the law. One example is known as the "Family Glitch

", which will leave nearly 2 million people, half of whom are children, without access to affordable coverage.[4] A similar problem arises for people who fall into the Medicaid coverage gap—these are people who are ineligible for Medicaid in their state because the state chose not to expand eligibility rates, but are still below 100 percent of the federal poverty level (FPL) and therefore not eligible for coverage in the exchange either (which is only open to people between 100 and 400 percent FPL).[5]

The differing definitions of "affordability" are also causing problems. In order to be exempt from the individual mandate due to the unaffordability of insurance available through the exchange, the lowest cost plan must equal more than 8 percent of a person's income. However, for an employer to meet their responsibility of providing affordable coverage to their employees, they must only offer coverage that does not cost the employee more than 9.5 percent of an employee's income. The 1.5 percentage point gap in these two numbers could result in an individual being left without any truly affordable options for insurance. An employer offering coverage that is deemed affordable avoids the penalty under the employer mandate, whether the employee can actually afford the coverage or not. As a result, the individual becomes ineligible to receive subsidies to purchase coverage through the exchange, where a plan may be cheaper for that individual. So while the individual won't have to pay the mandate penalty, he/she may also not have any insurance.

THE INSURED

The ACA has also been responsible for shifting people between health insurance markets and types of coverage. The biggest increase has been in Medicaid and the Children's Health Insurance Program (CHIP), which has seen total enrollment grow from 57.8 million in 2013 to 70 million in 2015, an increase of 19.3 percent in just two years.[6] Children account for nearly 42 percent of total enrollment in these two programs. According to a RAND study, 80 percent of non-elderly adults either maintained insurance through the same means in 2014 as they had in 2013, or remained uninsured; the remaining 20 percent are no longer uninsured, newly uninsured, or receiving health insurance through a different means than they had the previous year.[7]

The majority of non-elderly adults continue to be insured through an employer-sponsored plan (up 8 million in 2014 to 116.9 million), as can be seen in the charts below, though at least 2.5 million people lost their employer-sponsored insurance between 2013 and 2014. (Researchers publishing in *Health Affairs* found similar estimates for the number of cancelled plans.[8]) Medicaid now serves as the primary source of insurance for 9 percent of the non-elderly adult population,[9] while the marketplace exchanges insure 2 percent.[10] Of the uninsured population prior to 2014, nearly 70 percent of them remain uninsured.

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MEDICAID COSTS

With much of the gains in insurance coverage coming from increased enrollment in Medicaid (which, combined with CHIP, now covers 70 million individuals, up from almost 52 million in 2010), the cost of this joint federal-state assistance program will undoubtedly rise, increasing burdens on both federal and state budgets.[11] CBO estimates Federal spending on Medicaid will be $335 billion in FY2015, with expenditures expected to grow by 75 percent over the next 10 years bringing federal spending on the program to $588 billion by 2025.[12] States, on average, cover 43 percent of the cost of the Medicaid program.[13] This amounted to $181 billion in FY2012, before the ACA's Medicaid expansion provisions went into effect and dramatically increased enrollment.[14] While the federal government is covering 100% of the cost of covering the "expansion population" through 2016 and is to continue to cover 90 percent of the costs, state budgets are already tight and will likely feel the strain of this new expense. Additionally, the "woodwork effect" will cost even non-expansion states up to $700 million.[15]

EXCHANGE ENROLLMENT AND COSTS

In 2014, the first year the ACA's health insurance exchanges were operating, 8.02 million individuals enrolled in a marketplace exchange plan. According to HHS, 2.57 million enrolled through a state exchange and 5.45 million enrolled through the federal exchange.[16] Even though the initial open enrollment period was 6 months long (October 1, 2013, to March 31, 2014), 47 percent did not enroll until the last month or during the Special Enrollment Period (which extended the deadline to April 19 in response to lower-than-expected enrollment).[17] Further, by the end of the year, only 6.7 million people were enrolled in an exchange plan.[18]

Among all enrollees, 6.67 million (83 percent) received federal financial assistance in purchasing a plan; however, many people received incorrect subsidy amounts and are having to reconcile those errors during tax season this year. Because subsidy amounts were originally calculated using 2012 income, which may be very different than actual income earned in 2014, it is estimated that between 4.5 and 7.5 million people will either have to pay back some of their subsidy ($794, on average) if income was higher than expected or will receive additional money ($773, on average) if income was lower than expected.[19]

In 2015, enrollment through the exchanges has increased to 11.69 million individuals as of February 15 (though enrollment is still ongoing since the deadline was extended to April 30). According to HHS and consistent with the CBO March 2015 estimate, 2.85 million enrolled through a state exchange and 8.84 million enrolled through the federal exchange.[20] Among all enrollees, 7.7 million received financial assistance to purchase a plan, costing the government $28 billion this year.[21

Table 1. Exchange Characteristics		
	2014	**2015**
Enrollment		

Federal	5.45 million	8.84 million
State	2.57 million	2.85 million
Total	8.02 million	11.69 million
Subsidies		
Enrollees Qualifying for Subsidy	6.67 million	7.7 million
Average Monthly Premium (after subsidy)	$82	$101
Average Subsidy Amount	76%	72%

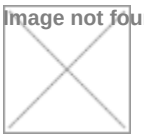
Costs to Individuals

With all of the shifting in the health insurance market between various types of coverage and new regulations on health insurance products, many individuals were unsure how these changes would impact their wallets.

In 2014, plan premiums, on average, were higher for those purchasing employer-sponsored insurance (ESI), compared with the average exchange premium. However, since the average exchange subsidy amount covered only 76 percent of the premium cost whereas employers covered 82 percent for their employees, on average, the premium amount paid by the individual was only slightly higher for those purchasing coverage through their employer ($90/month[22]) than those purchasing a plan through the exchange ($82/month). [23]

Further, exchange plans typically have higher deductibles ($2,910 in 2014 compared with $1,217 for ESI), co-insurance rates (20 percent compared with 19 percent), and caps on out-of-pocket expenses ($5,730 compared with $3,011), meaning a person with coverage through the exchange will be liable for more out-of-pocket expenses than an individual with ESI, on average.[24] For example, given total annual health care costs of $3,000 (in excess of premium payments), an individual with coverage through an exchange will spend $1,275 more than a person with ESI. This difference only increases as health care expenses increase. Further, CBO's latest report estimates that premiums for benchmark exchange plans will increase 8.5 percent on average per year from 2016-2018, which could make the problem even worse if employer-sponsored plans do not see the same growth rate.[25] *(All figures based on individual coverage in 2014.)*

While we don't yet have data on employer-sponsored plans for 2015, costs for exchange plans remain largely unchanged from last year. In 2015, the average subsidy amount covers 72 percent of premium costs and the average premium is $364 per month, meaning the cost to enrollees, on average, is $101 per month.[26] The average deductible is now $2,556 for a Silver plan.[27]

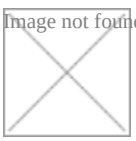


Overall Cost of the ACA

After examining the changes to the health insurance market and the corresponding costs to the individual, we must next examine at what cost to the taxpayer those changes have been realized. At the time of passage in March 2010, the CBO estimated the ACA (and its accompanying reconciliation legislation) would reduce the federal deficit by $143 billion between 2010 and 2019.[28] This net reduction would be the result of $788 billion in new spending on the law's various insurance coverage provisions, a reduction in spending of $511 billion in other areas (including Medicare), and $420 billion in increased revenue from new taxes and payments. CBO projected the number of uninsured would decrease from 50 million in 2010 to 23 million in 2019, when exchange enrollment would be 24 million, and the average exchange subsidy would reach $6,000 per person, for a total 10-year cost of providing coverage through the exchanges of $358 billion.[29]

Five years later, in CBO's March 2015 budget baseline, we can see how some of the costs have changed. Some of these changes are the result of having more accurate, timely information now that some of the provisions have gone into effect and we can see how consumers, insurers, and employers are actually responding to the effects of the law. Other changes in the numbers reflect the fact that cost estimates are done in ten year windows and many of the provisions of the legislation, particularly the costly spending provisions, were not set to go into effect until 2014 or later, nearly halfway through the original ten year window. Now, many of the provisions have gone into effect or will in the next year or two, allowing for the costs to be more fully accounted for in this latest estimate. In the ten years from 2016-2025, CBO now estimates the gross cost of the coverage provisions will be $1.707 trillion. [30] After accounting for expected revenue increases, the net cost of the coverage provisions is estimated to be $1.207 trillion over the next decade, and mandatory spending is projected to increase by $1.747 trillion under this law. The uninsured population, calculated to be 35 million in 2015, is projected by CBO to drop to 27 million in 2025, while exchange enrollment will double to 22 million by the same year, from its current level of 11 million. (Note that exchange enrollment is now predicted to be 2 million less in 2025 than it was first predicted to be in 2019.) The average subsidy in 2025 is expected to be $6,600/person, and total costs of providing coverage through the exchanges will be $849 billion from 2016-2025.[31]

CBO only originally estimated $211 million in unfunded mandates, but AAF's Regulation Rodeo has found that other hidden mandates in the bill—the 96 regulations implemented pursuant to the ACA thus far—are responsible for costs to our economy of $42.6 billion and 155 million paperwork hours.[32]



Bending the Cost Curve

In addition to paying for health insurance, there is the cost of actual health care, which includes hospital, physician and clinical services, medications and medical devices, public health initiatives, medical research, and more. Throughout the health care reform debate and beyond, the notion of "bending the cost curve" for providing these services has been a stated priority. As health care costs continue to rise and consume a larger share of our nation's GDP and our wallets, the imperative is to reduce the cost of care while maintaining or improving its quality. So far, the law is not a success in this respect.

The Altarum Institute recently published its latest Health Sector Trend Report showing that total national health expenditures grew 5.2 percent annually in 2014 from 2013.[33] However, growth in just the last quarter of 2014 was up 6.2 percent from the same quarter in 2013, and up 6.6 percent in the month of February this year from a year ago, which may indicate similar increases are to be expected as 2015 continues.[34]

While looking at the changes in growth rates from last year provides a good idea of the current trend, examining the changes over the last several years provides a more complete picture which is helpful in determining the cause of the changes. The conversation surrounding health care expenditures has been particularly interesting recently because of the occurrence of two simultaneous events, both of which may have had a large impact on health care spending: health care reform, of course, and the "Great Recession". The trends show that since the start of the recession, which began at the end of 2007, annual growth in health care spending decreased from 6.3 percent in 2007 to 3.8 percent in 2009, and hovered around the 4 percent mark for five straight years, as shown in the chart below.[35] Then, in 2014, health expenditures grew by 5 percent, the first significant uptick in some time. Many proponents of the ACA credit the law with the slowdown in spending growth and even contend that an increase was to be expected in 2014. This is due to the various provisions that took effect in 2014 to increase coverage, which should thus increase use of services and spending on health care. However, the slowdown in health care spending, dropping to 4.8 percent in 2008, correlates much more strongly with the recent recession than it does with passage of the ACA. The legislation, of course, was not signed into law until 2010, the third year of the slowdown.

Altarum: Annual Growth in National Health Expenditures, Overall and by Selected Categories[36]

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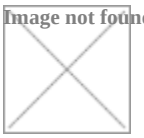
Further, when we look more closely at the breakdown of the increase in spending in 2014, we do not find a large increase in services as the ACA proponents' theory would suggest. Spending on services grew only 4.1 percent in 2014, up just 0.2 percentage-points from 2013. Breaking this down even further, the entire increase in health services is due to increases in hospital services; growth in physician services declined for a second straight year (chart below). This could imply that even though people now have insurance coverage, they either do not know how to appropriately use that coverage (continuing to seek non-emergent care at hospitals rather than a doctor's office) or they are not seeking routine care, potentially because the cost-sharing aspects of their insurance are too high.[37]

A report from athenahealth shows that there was barely any increase in new-patient volume in 2014, despite expectations of substantial increases by many.[38] The Commonwealth Fund also found that 43 percent of non-

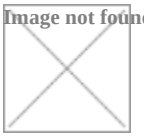
elderly adults in both Florida and Texas, two of the country's four most populous states, had problems accessing health care because of issues related to the cost of care.[39] Another report by the Commonwealth Fund documents other problems that people continue to have regarding health insurance and access to care, including high cost-sharing.[40] These reports underscore the issue that having insurance is not the same as having access to affordable health care.

Increased Medicaid enrollment as a result of expanded eligibility under the ACA may also be partly to blame for limited access to care; a study published by JAMA in 2007 found higher rates of hospital utilization among Medicaid patients.[41] One reason for the increased utilization among Medicaid patients is the low physician reimbursement rates. These prevent some providers from accepting Medicaid patients, causing them to seek care in the emergency room instead.

Altarum: Health Services Spending and Component Growth[42]



Kaiser: Excess Health Spending Growth Adjusted for GDP and Inflation[43]



Research by the Kaiser Family Foundation looks even more deeply at health care expenditure trends over the past few decades, specifically separating out "excess" health care spending, which is the amount that health care spending increases above growth in GDP and inflation. "Excess" health care spending began to rise again in 2009, after a steady decline beginning in 2003.[44] This pattern also does not fit the theory that growth in health care costs slowed because of passage of the ACA.

Conclusion

Five years after passage, there are few clear indications that the ACA has had its intended impact on cost of care and access to it. Meanwhile, the law costs significantly more than projected. We are unsure how many previously uninsured people have truly gained coverage because of the law. For many who have gained insurance coverage, they have not, in turn, been successful at gaining access to affordable care; they are paying premiums for plans that do not meet their needs and which include deductibles and coinsurance rates which inhibit the use of such coverage. National health care expenditures continue to rise, proving that we have been unsuccessful at bending the cost curve thus far. Going forward, health coverage policy solutions will need to focus on enlisting market forces to lower costs rather than merely subsidizing them.

Appendix

Federal Spending and Insurance Coverage	

	2010	2015	2010-2015 Change
Health Care Spending			
Total Spending	$2.6 trillion	$3.15 trillion^	+ $550 billion
Percent of GDP	17.40%	17.9%^	+ 0.5 percentage points
Impact of the ACA			
Net Ten Year Cost	-$143 billion	—	—
Mandatory Spending	$483 billion	$1,747 billion	+ $1,264 billion
Annual Cost of Regulations	—	$42.6 billion	—
Insurance Coverage			
Total Uninsured	50 million	35 million	-15 million
Percent Uninsured	19%	15%	-4 percentage points
Employer Sponsored Insurance	150 million	153 million	+ 3 million
Total Exchange	—	11 million	+ 11 million
Medicaid	51.8 million	63.9 million†	+ 12.1 million
CHIP	5.3 million	5.8 million*	+ .5 million

^ *As of Dec 2014*

† Total Medicaid/CHIP enrollment is 69.7 million as of Dec 2014; subtracted CHIP estimate

** As of Dec 2013*

Note: These numbers do not encompass the entire insured population, and thus do not add to the reduction in uninsured.

Cost of Self-Only Insurance Coverage

	Employer Sponsored Insurance		Exchange
	2010	2014	2014
Average Total Monthly Premium	$421	$502	$346
Average Employer Contribution	82%	82%	—
Average Employee Contribution	$75	$90	—
Average Subsidy	—	—	76%
Average Premium After Subsidy	—	—	$82
Percent Increase from Year Prior	5%	2.40%	45%[i]
Annual Deductible	$917	$1,217	$2,910
Co-Insurance (Inpatient)	18%	19%	20%
Annual Limit on OOP Expenses	$2134	$3,011	$5,730

[i] *For 27 year olds in the individual market*

[1] CBO estimated in 2010 that the number of uninsured individuals would be 26 million in 2015; it is now estimated by CBO to be 35 million.