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The U.S. Health Care System Before and After the Affordable Care Act: Better or Worse and What's Next?

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STATUS BEFORE THE AFFORDABLE CARE ACT

The opinion that the U.S. health care system before the Patient Protection and Affordable Care Act (ACA) was the best in the world appeared more widespread than facts and numbers support. There is no doubt that the system was by far the most expensive worldwide measured as a percentage of GDP, and also one of the most expensive in terms of dollars spent per capita. In 2009, the year before ACA kicked in, national health expenditure was $2.5 trillion, which represented 17.0 percent of GDP, or $8,023 for each person.[1] Table 1 shows the 10 most expensive health care systems in the world in 2009 assuming that at least $1,000 was spent per capita.

Table 1
Most Expensive Health Care Systems by National Health Expenditure as % of GDP (2009)[2]

	Health expenditure % of GDP	Health expenditure per capita
United States	**17.0**	**$8,023**
Denmark	11.5	$6,465
Germany	11.4	$4,753
France	11.3	$4,722
New Zealand	11.2	$3,145
Austria	11.2	$5,154
Canada	11.2	$4,582
Switzerland	11.0	$7,277
Portugal	10.4	$2,404
Belgium	10.4	$4,575

Moreover, quality metrics such as life expectancy at birth, life expectancy at age 60, infant mortality and mortality under age 5 suggested that overall, the system's performance was lacking. Table 2 shows these quality metrics among the same countries listed in Table 1.

Granted, some U.S.-specific characteristics that impact mortality have little or nothing to do with an efficient health care system, although this doesn't have the effect some have claimed. In one article from 2011, the author stated that if deaths from car accidents and violent crimes were removed, life expectancy

Table 2.
Countries as Selected in Table 1 Including Quality Categories and Corresponding Rankings (2009)[6]

	Life Expectancy at Birth[2]	Rank[3]	Life Expectancy at Age 60[3]	Rank[4]	Infant Mortality Rate[4]	Rank[4]	Under-5 Mortality Rate[5]	Rank[4]
United States	78.5	31	23.1	25	6.4	41	7.5	42
Denmark	78.9	30	22.1	34	3.5	14	4.2	15
Germany	80.0	21	23.0	26	3.6	17	4.3	16
France	81.1	10	24.7	2	3.5	14	4.3	16
New Zealand	80.5	15	23.8	13	5.2	36	6.3	36
Austria	80.2	18	23.3	22	3.7	20	4.5	21
Canada	81.0	11	24.1	9	5.0	34	5.7	33
Switzerland	82.1	2	24.7	3	3.9	25	4.6	22
Portugal	79.3	26	22.9	29	3.2	11	4.0	12
Belgium	79.8	22	23.2	23	3.7	20	4.6	22

in the United States would be the highest worldwide.[6] We tested this hypothesis and removed deaths due to homicides, traffic deaths and drug deaths, all notoriously high compared to other industrialized nations, from the life expectancy calculation. On average, we added 43 deaths per 100,000 for males and 20 deaths per 100,000 for females, which can be attributed to these three causes, back to the number of people alive at each age up to age 100.[7] The recalculated life expectancy is about 1.1 years higher for males and a meager 0.6 years higher for females. With these adjusted life expectancies, we would rank 28 (up from 33) for males and rank 30 (up from 33) for females among 183 countries, still well below countries such as Japan, Switzerland and Singapore, with life expectancies of about 83 years for males and females combined. These hypothetical rankings do not even take into account similar adjustments to other countries' life expectancies. Therefore, the quality of our system might well be the reason behind a relatively high mortality and other key indicators that other countries fare better in.

This all appears to be supported by several analyses that explicitly ranked health care systems from different countries:

- The World Health Organization (WHO), in its *World Health Report* of 2000, ranked the U.S. system 37th out of 191 countries in overall health system performance.
- According to a ranking by the Commonwealth Fund based on data from 2011, i.e., before main features of the ACA were implemented, the United States ranked dead last of 11 countries that included six G7 nations, the Netherlands, New Zealand, Norway, Sweden and Switzerland.[8]

We conclude objective parties would agree that the U.S. health care system, prior to implementation of the ACA, and as measured against goals of a functioning system, was mediocre at best.

STATUS AFTER THE AFFORDABLE CARE ACT

The ACA was signed into law on March 23, 2010, with goals that highly correlate with goals the WHO has stated for an efficient health care system:

1. Provide greater access to health coverage and reduce the number of uninsured
2. Bring down health care cost increases by encouraging a shift toward more efficient delivery and payment models
3. Add new consumer benefits and protection

The question now becomes, seven years after the ACA went into effect, is there evidence that our system has improved?

At first glance, quite a few features would seem to improve access and protection. The introduction of no pre-existing condition rejection, no rating for health conditions, essential health benefits mandate, no annual or lifetime cap on benefits and the ability to maintain young adults on their parent's plan are all new key provisions that could have a favorable impact on the system's quality. Could that already be supported by changes in some key metrics? Table 3 shows the development since provisions of the ACA have been introduced.

Although the measures appear to have improved numerically, the relative ranking in comparison to other nations has not shown any progress at this early stage of the post-ACA era. Life expectancy in recent years was certainly negatively affected by the concerning development of traffic deaths[11] and drug deaths, most notably as a result of the opioid addiction epidemic,[12] a negative trend that is not as pronounced in other industrialized nations. However, it is a little surprising that trend in infant mortality does not show a relative improvement considering the improved access to health care for individuals and expecting parents.

Table 3.
Quality Categories and Corresponding Rankings for the United States by Year from 2010 to 2015[10]

	Life Expectancy at Birth	Rank	Life Expectancy at Age 60	Rank	Infant Mortality Rate	Rank	Under-5 Mortality Rate	Rank
2010	78.7	30	23.1	25	6.3	41	7.4	42
2011	78.7	32	23.2	29	6.1	41	7.2	42
2012	78.8	31	23.3	29	6.1	42	7.1	42
2013	78.9	31	23.3	30	5.9	43	6.9	43
2014	79.1	31	23.5	30	5.7	44	6.7	44
2015	79.3	31	23.6	30	5.6	44	6.5	44

Regarding access, it is undeniable that an important goal of the ACA was achieved—the increase of the insured population. Possibly the most disturbing fact about the old system was the high number of uninsured, which in 2009 stood at 17.5 percent, or 54 million people. In 2016, this ratio was estimated to be about 10.4 percent, which implied a reduction of around 20 million individuals who were previously without insurance. It was in particular the main features of the ACA that were introduced in 2014 that had a positive impact on the insured population. Figure 1 shows the uninsured rate among the nonelderly population from 2009 to 2016.[13]

According to a report released by the Department of Health and Human Services, 13.8 million people are expected to have selected a plan by the end of this year's open enrollment period, an increase of 1.1 million people, or nearly 9 percent, over the 12.7 million plan selections at the end of 2016 open enrollment.[14]

However, the substantial reduction of the uninsured population has come with a hefty price tag. National health expenditures have continued to climb and are expected to have reached an unprecedented level of 17.8 percent of GDP, or $3.2 trillion, in 2015—rising tendency.[15] No other nation's system ever has caused this degree of financial burden. It is fair to state that the ACA has achieved practically nothing to reduce health care costs to a sustainable level.

Going back to the seminal question raised, the ACA has set the stage for a better health care system. Several provisions and a high insurance penetration rate correlate with the quality of a health care system. However, it is also clear that the current status is unsustainable and significant modifications need to be made. The key area that needs to be fixed is to curb costs while maintaining or gradually improving the quality of treatment. As it is typical in other industries, costs may need to be reduced where incurred to produce corresponding goods or services. In our industry, this mainly means costs for hospital care, physician services and prescription drugs.

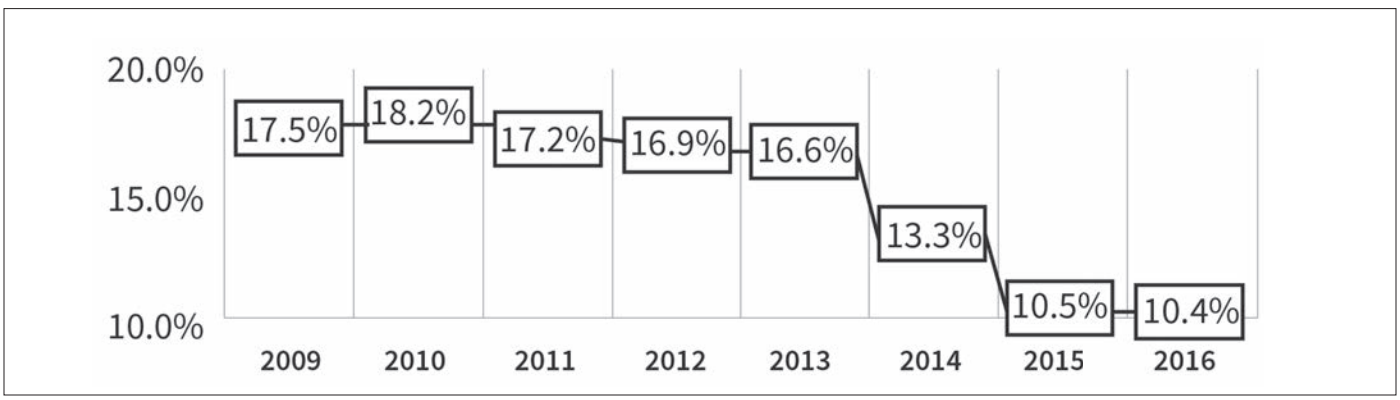
WHAT IS NEXT?

Together with the Republican control of Congress, the Trump administration is certain to bring about dramatic changes to the existing system. Even though the GOP does not have a 60-vote majority in the Senate to quickly repeal the ACA entirely, reconciliation, a complex procedural process that allows for certain pieces of legislation to pass by a simple majority, may be used to push changes through. This in combination with a series of executive orders that the new president is likely to put into effect will allow the Republicans to keep their promise to repeal quickly.

The second part of the repeal-and-replace commitment, however, will take longer, most likely much longer. There have been discussions of a two- to three-year horizon or even putting an alternative plan off until the next presidential election. It is obvious that our health care system is approaching an uncertain, political and complicated phase. Concrete details or early indications around what the upcoming repeal and following replacement might entail are sparse, and any potential market disruption is impossible to predict at this point. However, at time of writing, the following have surfaced early in this process as items that will potentially be repealed or most likely will stay.

- Dependent coverage to age 26 will likely stay, as might unlimited policy maximums.
- The most popular provision of the ACA, no exclusions for pre-existing conditions, will most likely be left in place. It simply seems politically impossible to remove this regulation entirely, since millions of President Trump's supporters would lose coverage. A softer version, however, such

Figure 1.
Uninsured Rate Among the Nonelderly Population, 2009–2016



as limiting protection to individuals who maintain continuous coverage, appears to be possible.

- Medical underwriting may return in a limited capacity, such as when an individual does not enroll during the open enrollment period.
- The individual and employer mandates and penalties imposed on individuals without insurance and employers that do not offer coverage may be eliminated. The consequences of repealing the individual mandate without other incentives introduced might result in dropout of the healthiest people, leaving a sicker population in the system.
- Premium subsidies for coverage that could be obtained through the existing public exchanges may end and could be replaced by tax credits.
- Financial support provided to states that have expanded access to Medicaid could be eliminated. Instead, Medicaid may be converted into a block grant type of program, giving individual states more flexibility to adopt what appears to work locally.
- State high-risk pools to cover sick uninsured people may come back. However, at this stage of the discussion it is unclear how this could be financed.[14]
- Variations or flexibility in product design and pricing capabilities may resurface, which would help reduce the risk of adverse selection in the individual and small group markets.
- ACA-mandated benefit requirements such as mental-health services and maternity care may be scrapped or limited.
- Health savings accounts that allow tax-free contributions may be expanded.
- Selling insurance across all state lines may be allowed, to increase competition.

Beyond coverage expansion, the ACA has also had an impact on how health care is delivered today compared to the pre-ACA environment. Preventive care is a stronger focus, and providers are gradually moving away from traditional fee-for-service structures where every single examination and procedure is reimbursed. Instead, more features of a risk-based model have been introduced to Medicare, Medicaid and also private insurance. It will take a detailed and comprehensive plan to replace many of the ACA features that have been introduced over the last seven years and avoid political fallout. At this point, such a plan, concept, or consensus does not seem to exist.

Tremendous uncertainty will prevail and the only certainty for all players in the health care industry is that changes are coming. And did we mention that it is going to be political and complicated? It is prudent to be prepared for any modifications, including radical changes and a complete demolition of the ACA. Time will tell if the status of our health care system after repeal and replacement of the Patient Protection and Affordable Care Act, the most significant health care reform in half of a century, will improve. ■

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ENDNOTES

1 VIX World Bank, *http://data.worldbank.org/.*

2 In years for male and female combined.

3 Among 183 countries.

4 Per 1,000 live births.

5 World Bank, *http://data.worldbank.org/.*

6 Avik Roy, "The Myth of Americans' Poor Life Expectancy," Forbes Magazine, November 23, 2011, *www.forbes.com/sites/theapothecary/2011/11/23/the-myth-of-americans-poor-life-expectancy/#588cf7583b35.*

7 Death rates due to homicides, traffic deaths, and drug deaths range from 4 to 63 per 100,000 by age band for males and 2 to 31 for females.

8 Commonwealth Fund, "US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives," press release, June 16, 2014, *http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last.*

9 World Bank, *http://data.worldbank.org/.*

10 U.S. Department of Transportation,"2015 Motor Vehicle Crashes: Overview," Traffic Safety Facts, August 2016, *https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812318.*

11 Centers for Disease Control and Prevention, "Injury Prevention and Control: Opioid Overdose," *https://www.cdc.gov/drugoverdose/data/.*

12 Kaiser Family Foundation, "Uninsured Rate Among the Nonelderly Population, 1972–2016," *http://kff.org/uninsured/slide/uninsured-rate-among-the-nonelderly-population-1972-2016/; 2016 data is for Q1 and Q2 only.*

13 Department of Health and Human Services, "Health Insurance Marketplace Enrollment Projections for 2017," ASPE Issue Brief, October 19, 2016, *https://aspe.hhs.gov/sites/default/files/pdf/211056/EnrollmentProjections.pdf.*

14 In 2016, the state of Alaska resurrected its high-risk pool funded by a levy on all insurance premiums including non-health-related premiums written in the state.