The ACA@10

By Joan C. Barrett and Kurt Wrobel

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March 23, 2010, the day the Affordable Care Act (ACA) was signed into law, was a day of great promise for everyone without health insurance—it promised access to affordable health care. Ten years later, the question is: Was that promise kept? Certainly, it is an achievement that there are now 20 million more people insured than there were in 2010. Yet, there are still 30 million Americans[1] who are uninsured, and many more who are struggling with paying premiums and the cost-share on their existing coverage. As the 2020 U.S. election draws near, we need to be able to understand the ACA's real-world application more fully, as the electorate decides where we want to go from here. Should we "repair" or "replace" the ACA?

To help us answer this question, the Health Section Council (the Council) of the Society of Actuaries (SOA) launched the ACA@10 Strategic Initiative last year. This initiative consisted of a data-driven research project, entitled "Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA." This research, which was authored by Paul Houchens, FSA, MAAA; Lindsy Kotecki, FSA, MAAA; and Hans Leida, Ph.D., FSA, MAAA, looks at measures of success for the ACA from a number of different perspectives.

In addition to the research, the Council commissioned several articles examining specific aspects of the ACA in more depth—the result of which comprise this web-exclusive series. In each case, the authors are health actuaries who work with government agencies, health plans and providers at a detailed level on a daily basis, and they bring a practical perspective to the table.

Authors and topics of these articles include:

- David Dillon, FSA, MAAA; Michael Lin, FSA, MAAA; and Matthew Damiani; Successes of the ACA
- Greg Fann, FSA, FCA, MAAA, The Elusive Paradoxes of the ACA
- Ryan Mueller, FSA, MAAA, The ACA's Impact on Rural Areas
- Joan C. Barrett, FSA, MAAA, Managed Care 3.0

AN ACA OVERVIEW

The primary goals of the ACA were to make affordable health care available to more people, and to support innovative medical care delivery methods designed to lower the cost and improve the quality of health care. To make affordable health care more available, the ACA provided for an expansion of Medicaid to include those making under 138 percent of the federal poverty level (FPL) and a new "marketplace" or "exchange" infrastructure. A tax penalty was imposed on people who were not covered by "minimum essential health coverage."[2]

The hallmark of the exchange infrastructure was the ability for consumers to choose from a set of plan designs that were roughly equivalent in benefit value for a given "metal level." The metal levels group plans based on benefit richness, with the plans with the lowest cost-share falling into the platinum level and plans

with the highest cost-share falling into the bronze level. To keep costs affordable, consumers at certain income levels are entitled to subsidies in the form of advance premium tax credits (APTCs) to offset the monthly premium costs and cost-sharing reduction (CSR) subsidies to offset expenses associated with deductibles, coinsurance and copays. The ACA also provided for a safety net system using risk adjustment to make sure health plans competed only on factors like price, provider access and customer service, and not on risk selection.

To lower the cost of health care and improve the overall quality, the ACA also provided for the Centers for Medicare & Medicaid Services (CMS) Innovation Center, which is now focusing on its Quality Payment Program and Advanced Alternate Payment Programs, as well as evaluating and advancing best practices.[3]

The ACA has gone through a number of changes since it was originally passed in 2010, including:

- In 2012, the Supreme Court ruled the federal government did not have the authority to mandate Medicaid expansion.
- The tax penalty for the individual mandate was repealed effective 2019.[4]

OUR ANALYSIS AND FINDINGS

Several keys themes emerged as a result of our analysis and research, including:

- **The uninsured rate.** Although the reduction in the uninsured rate was impressive and nearly on par with projections, the source of the reduction was unexpected. The Congressional Budget Office (CBO) originally estimated that by 2018, 26 million people would be covered through the exchanges. In fact, only about 10 million people were covered. Other factors influencing the reduction in the uninsured population include Medicaid expansion and the overall improvement in the unemployment rates.[5]

- **Medicaid.** Originally, the CBO projected that Medicaid enrollment would increase by 11 million beneficiaries by 2018 as a result of Medicaid expansion and additional enrollment of the existing Medicaid-eligible population. The latest numbers show that Medicaid enrollment expansion was closer to 16 million beneficiaries.[6] After the passage of the ACA, CMS became much more involved in the program, with an emphasis on delivery system and payment reform.

- **Employer-sponsored insurance.** Prior to the implementation of the state exchanges, there was some speculation on how many employers would stop offering health insurance coverage and push their employees to the exchanges. There has, however, been no material change in employer-sponsored enrollment—with one exception. We continue to see a decline in coverage among employers with fewer than 50 employees, a continuation of a trend that began before the passage of the ACA.

- **The remaining uninsured.** Approximately 30 million people remained uninsured in 2018. About two million people fall into the "coverage gap," which means they make too much money to qualify for Medicaid but not enough money to qualify for subsidies in the exchanges.

- **Affordability.** Health care remains unaffordable to many Americans. In recent years, the federal government and health plans alike have focused considerable efforts on developing alternative payment methods. While these efforts are beginning to show results, they may not be sufficient to reduce the overall cost of care. One way to make care more affordable is to supplement these efforts by focusing on the underlying disease burden and the new technologies and analytical methods that help reduce the disease burden in a cost-effective way.

- **Market stability.** Premium rates in the exchanges are beginning to stabilize in many states, in large part due to mature data and more stable competition. An important factor in assessing market stability is the underwriting cycle. The underwriting cycle refers to the natural tendency of organizations, like health plans, to balance competitiveness with profitability.[7]

- **The rural population.** The ACA probably has had a greater impact on people living in rural areas than it has on other populations. Many more people living in rural areas are being covered now, but those who are not subsidized often pay a much higher premium than those living in urban areas.

- **ACA complexity.** The ACA is complex and often counterintuitive. For example, consumers in some markets find it less expensive to buy a plan at a higher metal level. Similarly, many insurers find the risk-adjustment process, which is supposed to provide some stability to the pricing process, often results in some confusion and lack of transparency.

LESSONS LEARNED

Health care is local. Each area has its own unique challenges based on its state's regulatory environment, its population, provider community and insurance availability. Whatever changes we make to the ACA, or any system that replaces it, must reflect that reality.

Change is inevitable. The delivery of health care, the provider community and the underlying demographics are constantly changing. Again, any changes we make to the ACA, or to any system that replaces it, must be able to accommodate the changes. Health care is complex. Attempts to solve one problem often end up creating new problems. Comprehensive analytics are required.

WHERE DO WE GO FROM HERE?

Health actuaries are constantly analyzing and reviewing what is going on in health care. To find out more information about our work, please visit the Health Section Council webpage or our LinkedIn subgroup page. You can also follow us on Twitter and LinkedIn using the hashtag *#soahealth*.

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ENDNOTES

1 Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029. *Congressional Budget Office,* May 14, 2019, *https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf* (accessed February 24, 2020).

2 Centers for Medicare & Medicaid Services. No Health Insurance? See if You'll Owe a Fee, The Fee for not Having Health Insurance. *HealthCare.gov, https://www.healthcare.gov/fees/fee-for-not-being-covered/* (accessed February 24, 2020).

3 Centers for Medicare & Medicaid Services. About the CMS Innovation Center. *CMS.gov,* February 14, 2020, *https://innovation.cms.gov/about* (accessed February 24, 2020).

4 Houchens, Paul, Lindsy Kotecki, and Hans Leida. *Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA.* Society of Actuaries, March 2020, *https://www.soa.org/resources/research-reports/2020/50-states-50-stories/* (accessed March 21, 2020).

5 Ibid.

6 Ibid.

7 Ibid.