A Critical Appraisal of the Affordable Care Act

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Before we can assess the Affordable Care Act (ACA) we need to know what features produce an effective health care system. Fortunately the prestigious Institute of Medicine has offered such guidelines in their exhaustive 2004 report entitled "Insuring America's Health: Principles and Recommendations." The 5 principles necessary for an effective, comprehensive and equitable health care system are as follows:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient- centered, and equitable.[1]

Let's review how well the ACA fares with regard to the above principles:

Universality

The ACA is not universal. In May 2013 the Congressional Budget Office estimated that the ACA will leave 31 million people uninsured when fully implemented in 2023 which is a little more than half of the close to 50 million who are uninsured today.[2] Due to stringent Medicaid eligibility requirements in some states and the rejection of Medicaid expansion in others, 2/3 of poor African Americans and 50% of single moms living in poverty will remain uninsured.[3] The Kaiser Family Foundation estimates that in Oregon the ACA will lead to a 51% reduction in the uninsured rate leaving 337,000 Oregonians uninsured in 2022.[4]

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2. Congressional Budget Office. (2013). CBO's Estimate of the Net Budgetary Impact of the Affordable Care Act's Health Insurance Coverage Provisions Has Not Changed Much Over Time. Retrieved from: http://www.cbo.gov/publication/44176

3. Tavernice, S., Gebeloff, R. (October 2, 2013) Millions of poor are left uncovered by health law. New York Times. Retrieved from: http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?pagewanted=1&_r=0

4. Hollahan, J., Buettgens, M., Carroll, C. & Dorn, S. (2012) The Cost and Coverage Implications of the ACA Medicaid Expansion: Natioal ans State-by-State Analysis. The Urban Institute. The Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. Henry J. Kaiser Family Foundation. November 2012. Retrieved from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf

Continuity

The ACA leaves in place a patchwork system of insurance programs including Medicare, Medicaid, the VA system, employer-based private health insurance, and individual or small group private insurance purchased through an exchange. Each system of financing has its own set of eligibility requirements and coverage details. If an individual loses their job, gets a divorce or has a change in income, their insurance will change or be dropped. Inevitably eligibility requirements requiring waiting periods of up to 3 months before insurance plans can be purchased will lead to gaps in coverage over time.[5]

Continuity is even more important with regards to health delivery. Multiple studies have demonstrated that patient-physician continuity in pediatric and adult settings reduce costs and hospitalizations while improving patient satisfaction.[6] [7] [8] [9] Under the ACA, however, circumstances leading to abrupt changes in both patients' primary care and specialist providers remain outside of their control. For example a patient's physician could decide to stop accepting Medicaid patients or could be dropped from an insurance company's network. In addition, a change in insurance necessitated by personal circumstance could interrupt due to insurance provider networks.

There are signs that this will be especially prevalent in insurance purchased via the exchanges. Insurance companies will attempt to drive down their premiums by skimping on their provider networks. In Los Angeles Health Net's premiums for the exchange are $100 less per month than their nearest competitor because their provider network excludes thousands of doctors. [10] In the Pacific Northwest, Seattle Children's Hospital has been dropped from 5 out of 7 insurance networks available on the exchange which will lead to disruption or delay in care for many vulnerable pediatric patients.[11] Due to a fight between two large insurers in Pittsburg, patients-included those with lung and breast cancer- were informed they were no longer able to see the specialists that had diagnosed and treated their conditions when they fell ill because their doctors were no longer in their insurer's network [12]

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5 . US Department of Labor. (2013) Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act. Retrieved from: http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26730&AgencyId=8&DocumentType=1

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Affordable for Individuals and Families

The cost of private health insurance continues to surpass inflation. Workers pay 47% more for insurance now than in 2001 even though their wages have increased only 18%. In the last 10 years the price of insurance for a family has increased to close to $15,000 a year.[13] The ACA provides tax-payer supported premium support to help individuals and small businesses purchase insurance. Even with this support a family of 3 earning $56,000/year will spend $5,320 on premiums. They face cost sharing in the form of deductibles, copays and coinsurance of $7,973 which leads to a total possible cost of $14,293 or 24% of their income.[14] A typical family of four in Oregon with an income at 200% of the Federal Poverty Line or $47,100 per year (close to the median income in Oregon of $50,000/year) even with maximum tax payer subsidies will spend 6.3% of their income on premiums and up to 18% of their income on premiums and out-of-pocket costs combined if they fall sick.[15] Clearly this is not affordable or sustainable for families.

The ACA requires guarantee issue insurance plans and, thereby, reduces the ability of the insurance companies to deny coverage to potentially less healthy individuals and families. Unfortunately the rules still allow for insurance companies to charge premiums up to three times as high for older adults as opposed to younger adults and 50% more for smokers.[16] This likely will push premiums higher than that which is affordable for many Oregon families.

In our current system of care, on which the ACA is based, over 60% of personal bankruptcies are due to medical debt and more that 75% of those falling into bankruptcy had medical insurance when they fell ill.[17] Applying these figures to the 15,281 personal bankruptcies filed in Oregon in 2012, means almost 10,000 Oregonians (9,490) were driven to bankruptcy by medical debt.[18] In Massachusetts, which implemented health reform closely resembling the ACA, medical bankruptcies increased by 33% from 2007 to 2009 and 89% of bankrupted individuals had insurance coverage when they fell ill.[19]

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14. Lange, A. (2012). Beyond the Affordable Care Act: An Economic Analysis of a Unified System of Health Care for Minnesota. Growth and Justice.

15 Ibid.

16**15.** Budnik, N. (June 21, 2013) Oregon smokers face new costs: most health insurers to charge more for habit. The Oregonian. Retrieved from: **http://www.oregonlive.com/health/index.ssf/2013/06/some_oregon_insurers_will_char.html**

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Affordable and Sustainable for Society

Currently the US spends 17.6% of GDP on health care which is more than double the average of other industrialized nations. The ACA does little reduce these costs. By 2021 we will be spending close to 1in 5 dollars of our economy on health care at 19.6% of GDP.[20] The high cost of health care in the United States reduces global competitiveness, and hampers state and local governments and other public agencies that provide health insurance for their employees.

There are no proven cost containment provisions in the ACA including health care delivery changes such as the CCO experiment in Oregon. Other nations reduce cost by retaining the ability to negotiate and control prices and budgets while reducing administrative costs. These single or multi-payer systems allow governments to negotiate lower prices from doctors, hospitals and pharmaceutical companies. For example, an average hospital stay in the US costs $18,000 compared to an average of $6,200 in the OECD while the US price paid for drugs is twice that of other industrialized nations. [21] Our average health spending is $8,000 per person- twice the OECD average despite having fewer doctors, less doctors' visits, and fewer and shorter hospital stays per capita.[22]

In terms of administrative costs, health experts estimate that the US health care system wastes $350 billion dollars per year on bureaucracy[23]- which is roughly 300 % higher than the OECD average.[24] Administrative costs derive from health insurance company business practices, advertising, billing and profit as well as the high administrative expense for physicians who, on average, spend more than $80,000 a year and 4 times what a Canadian doctors spends on billing and collecting fees.[25] The ACA adds additional administrative burdens to the system. In fact, Oregon is spending $300 million dollars or 1% of our yearly state budget just to set up the insurance exchange.[26]

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A measure of whether the ACA is sustainable over the long haul is Massachusetts. Enacted in 2006, the Massachusetts health care system is very similar to the ACA. A report by MassCare reports that after 5 years of experience reform has led to exorbitant costs for the state. In fiscal year 2009 alone the cost of reform was $800 million dollars and health care costs in Massachusetts remain the highest in the nation. In order to afford reform, Massachusetts dropped legal immigrants from the plan, cut spending on public hospitals for the poor, decreased plan benefits and increased cost sharing. Most of the increased costs were born by the middle and lower classes. The report concluded: "There is general agreement that the Massachusetts reform is itself not sustainable without effective cost control."[27]

Promoting Access to High Quality Care

As health care costs continue top rise under the ACA as they did in Massachusetts, health insurance plans will likely increase premiums and cost sharing in order to meet minimum benefits and guarantee issue provisions of the ACA. High-deductible plans will become common place. In 2012, three quarters of employers offered their employees high-deductible plans and experts report that by 2016 the majority of health insurance options will be high-deductible. [28] Why does this matter? As we have seen above, individuals and families will not be able to afford premiums and out-of-pocket costs even with tax payer supported subsidies and this will have a direct and dramatic impact on access to care.

High cost sharing reduces access to care. One study showed that 57% of low-income families delay care if they were enrolled in a high-deductible health plans with out-of-pocket expenses of more than $500.[29] Another study showed that public insurance with higher cost sharing reduced the use of preventative care services.[30] Further research shows that children with asthma are less likely to fill needed medication as cost sharing increases[31] and this leads to a decline in health outcomes.[32] Another study demonstrated that higher patient out-of-pocket costs for medications in those suffering from rheumatoid arthritis led to an increase in health care utilization and cost.[33] So it is clear that the ACA,

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despite its subsidies, will not limit out-of-pocket spending to levels that individuals and families can afford and, increasing cost shifting to patients will result in a decrease in access to appropriate preventative care thereby worsening health outcomes.

The Medicaid expansion under the ACA will cover a large portion of the uninsured and is a key aspect of the ACA in trying to ensure adequate access to high quality and efficient health care services. The Oregon Health Plan will play a large role. However, previous expansions of the Oregon Health Plan (OHP) have been especially vulnerable to budget pressures. In past years tens of thousands of OHP patients have been cut from the program while in other years medical provider reimbursements have been cut. It is conceivable that expected CCO savings for OHP members do not materialize or health care spending rises faster than expected leading to reduced federal support for state Medicaid expansion. This will lead to either reduction in services, reduction in eligibility or reductions in provider reimbursement. In turn, access to health care services for the poor will decrease.[34] Medicaid reimbursement cuts will reduce participating physicians and significantly decrease patient access to care.[35]

Even with a functioning Medicaid system, patients face discrimination from health care providers. In Chicago pediatric specialist denied appointments to Medicaid patients 66% of the time versus 11% for those children with private insurance while wait times for an appointment if they were not denied was 22 days longer for Medicaid patients than those with private insurance.[36] So although the ACA is basing much of its expansion of insurance on increasing Medicaid enrollment, it may not be sustainable for states and, furthermore, patients in Medicaid programs will have reduced access to health care services because of provider discrimination and non participation.

There are a myriad of provisions in the ACA that aim to improve quality of care including supporting primary care, improving equity and reducing disparities. There is a section regarding implementation of a national program on disease prevention and health promotion. Incentives are built in to help shape the medical workforce. All of these programs and incentives are important in improving the quality of our health care delivery. But without a functioning, and sustainable financing plan many of these programs will lose their effectiveness or fail to produce the results envisioned by the Obama administration.

Moving Beyond the ACA

As we have seen in the discussion above, the ACA was built on the crumbling foundation of a for profit, employer-based method of financing that has led to sky rocketing premiums, health care costs and numbers of uninsured and under-insured over the last

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34. Coughlin, T.A., Corlett, S. (2012). ACA Implementation-Monitorin and Tracking: Oregon Site Visit Report. The Urban Institute. Retrieved from :http://www.urban.org/publications/412498.html.

35. Pear, R. (2013, February 25) States Can Cut Back on Medicaid Payments, Administration Says. *The New York Times.*

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decade. The ACA hopes, with tax payer subsidies, that it can right the ship. But, as the Massachusetts plan has shown, increasing insurance has not led to universal, affordable access to health care services and, likely, the lack of cost containing measures will lead to a collapse of the system in the end.

Fortunately there is a way forward that can provide access to affordable and universal health care services. Every other industrialized nation provides universal access to health services at roughly half of what we pay in the U.S. and their health outcomes are better. Their systems rely on three fundamental criteria: 1.) The health system must be universal-no-one is left out; 2.) There must be one single comprehensive system of health benefits for everyone; and 3.) Financing of the system must be not-for profit with limited cost sharing. [37]

Universality ensures that those with health care needs are never turned away or driven into debt or impoverishment from medical bills. It also sets a standard that access to comprehensive health care services is a human right and the provision of such services is the responsibility of government. The second criteria, that a health system have one comprehensive system of benefits for everyone, ensures that both rich and poor have a vested interest in the success of the health system. It reduces administrative costs, improves efficiency, streamlines medical records and encourages preventative services and, most importantly, allows the payer(s) to negotiate down medical and pharmaceutical prices. Since everyone is in the same risk pool, the relentless push to avoid paying for patients and transfer the cost to another payer in the system is eliminated. The third criteria of using a not for profit system to finance health services ensures that the financing system is there to pay for medical bills, not to create profit. This puts the focus on customer service and efficiency, not on trying to avoid paying for the sick in the pursuit of profit.

Health Care for All-Oregon is a state-wide coalition that helped write HB2922, which establishes the Affordable Health Care for all Oregon Plan. It is a universal, publicly funded health care program that includes all of the IOM principles. It will, therefore, deliver universal, continuous health care services that will be affordable for both families and society as a whole. It will provide the context for access to high-quality, efficient and timely health care for all Oregonians.

37. Reid, T.R. (2009). The Healing of America: A Global Quest for better, Cheaper and Fairer Health Care. New York, NY: Penguin Press.