# A Critical Appraisal of the Affordable Care Act

HB2922 Health Committee Hearing Testimony May 13, 2013

Peter Mahr, MD

Before we can assess the Affordable Care Act's (ACA) effectiveness we need to know what we are looking for in a health care system. The prestigious Institute of Medicine has offered guidelines in their 2004 report "Insuring America's Health: Principles and Recommendations." The 5 principles 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 July 2012 the Congressional Budget Office estimated that the ACA will leave 30 million people uninsured which is more than half of the close to 50 million who are uninsured today.[2] Given that Oregon has 1.2- 1.3% of the US population that will mean that roughly 375,000 Oregonians or will be uninsured after the ACA is fully implemented.[3] Are we really paying $100 billion dollars a year for a health care program that will leave fully 10% of Americans and Oregonians uninsured?

**Continuous**

The ACA leaves in place a patchwork system of 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 before insurance plans can be purchased will lead to gaps in coverage over time. Each insurance company has a different network of participating providers. When a person switches from one insurance policy to another they will be forced to change doctors or hospitals leading to disruption of care, inefficiency of care and gaps and difficulty in accessing medical records.

**Affordable for Individuals and Families**

The cost of private health insurance continues to surpass inflation. If current increases of premiums and wages continue it is estimated that insurance premiums will surpass wages in 2025.[4] 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.[5] 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.[6] Clearly this is not affordable or sustainable for families.

The bronze plan only covers 60% of the benefits covered by the insurance and leaves families open to up to $11,900 of out-of-pocket costs. Sure, there are subsidies to protect those of lower incomes from rising premiums and out-of-pocket costs. But 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. Considering the average cost of a hospitalization in the US is $18,000[7] it would not take much to swamp a family budget.

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 in penalties for smokers. Tax subsidies would not be available to subsidize the smoker penalty so that a 60 year old smoker making $35,000 a year would pay $3,325 in premiums (after tax subsidies reduce the original premium price of $10,172) and a penalty of $5,086 for a total cost for health insurance of $8,411, or 24 percent of income.[8] This likely will push premiums higher than that which is affordable for many Oregonians.

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.[9] If these figures are applied to the 15,281 personal bankruptcies filed in Oregon in 2012[10] there were almost 10,000 Oregonians (9,490) driven to bankruptcy by medical debt. In Massachusetts, which implemented health reform that is considered to be the model for the ACA, medical bankruptcies remained significantly above 50% of all personal bankruptcies (53% in 2009 and 59% in 2007) and total medical bankruptcies increased by 1/3. Incredibly, 89% of bankrupted individuals had insurance coverage when they fell ill.[11]

**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 1 in 5 dollars of our economy on health care or 19.6% of GDP.[12] This is a huge drag on business and governments. Health care costs are one of the most important reasons businesses site for barriers to expansion and small business struggle the most with costs. Although the ACA promises to enable small businesses to afford health insurance for their employees there are ominous signs that this may not be as easy to arrange as originally portrayed. Just recently the Obama administration, at the behest of large private insurance companies, announced they were delaying the opening of small business insurance exchanges until 2015.[13]

There are no true cost containment provisions in the ACA other than to pilot health care delivery reforms such as the CCO experiment in Oregon. Other nations reduce cost by retaining the ability to negotiate and control prices and budgets. These single or multi-payer systems use their universal unified systems to negotiate lower prices from hospitals and pharmaceutical companies. On average a hospital stay in the US costs $18,000 while in other industrialized nations it costs $6,200 and the US price paid for drugs is twice that of other industrialized nations. [14]

Finally, the ACA does little to reduce administrative costs. Health experts estimate that the US health care system wastes $350 billion dollars per year on administrative costs.[15] Much of these administrative costs derive from the myriad of health insurance companies and plans as well as the administrative costs for billing from doctors and hospitals that have to deal with these plans. The ACA adds further 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.[16]

A measure of whether the ACA is sustainable over the long haul is Massachusetts. Enacted in 2006, the Massachusetts health care system has been deemed the model fort the ACA. A report by MassCare shows that after 5 years of experience it has led to exorbitant costs for the state. In fiscal year 2009 alone the cost of reform was $800 million dollars. Health care costs in Massachusetts are the highest in the nation. In order to prop up the reform effort 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.”[17]

**Promoting Access to High Quality Care**

As health care costs continue to rise under the ACA as they did in Massachusetts, health insurance plans will likely increase premiums and cost sharing. High-deductible plans will become common

place. In 2012 three quarters of employers offered their employees high-deductible plans as one option and experts report that by 2016 the majority of health insurance options will be high-deductible.[18]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 individuals and families will reduce, skimp or delay care when they are faced with high out-of-pocket costs: 57% of low income families delay care if they were enrolled in high-deductible health plans with out-of-pocket expenses of more than $500.[19] Another study showed that public insurance with higher cost sharing reduced the use of preventative care services.[20] Further research shows that children with asthma are less likely to fill needed medication as cost sharing increases. Another study demonstrated that for rheumatoid arthritis patients' higher out-of-pocket costs for medications led to an increase in health care utilization and cost.[21] So it is clear that the ACA, 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 and preventative care while increasing highly expensive tertiary care.

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. In other years medical provider reimbursements have been cut. In fact, in the 2011-12013 budgets Medicaid rates to providers were cut by more than 10%. 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.[22] A foreshadowing of this possibility came with the recent court decision allowing states to cut Medicaid reimbursement under the Medicaid expansion in ACA. Medicaid reimbursement cuts will reduce participating physicians and significantly decrease patient access to care.[23]

Even with a functioning Medicaid system, patients face discrimination from health care providers. A study in Chicago demonstrated that children on Medicaid were denied appointments with specialists 66% of the time versus 11% of the time for those with private insurance. Their wait for an appointment if they were not denied was 22 days longer than those with private insurance.[24] 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 and will be important. 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 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.) Health systems must be universal. Everyone is included and no-one is left out; 2.) There must be one single comprehensive system for everyone; and 3.) Financing of the system must be not-for profit and cost sharing must be limited. [25]

The first criteria of universality ensures that those with health care needs are never turned away or driven into debt or impoverishment due to inability to pay medical bills. It also sets a standard that access to necessary health care services is a human right and the ability to provide for such services is a the responsibility of the government. The second criteria, that a health system have one comprehensive system for everyone, ensures that both rich and poor have a vested interest in the success of the health system. It also reduces administrative costs, improves efficiency, streamlines medical records and encourages preventative services. Finally, it 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- using a not-for-profit system to finance health services ensures that the financing system is there to pay for medical bills, not to make a profit. This puts the focus on customer service and efficiency, not on trying to avoid paying for the sick in the pursuit of profit.

HB2922 which establishes the Affordable Health Care for all Oregon Plan is a universal, publicly funded health care program that meets the all three criteria. 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 just as the Institute of Medicine recommended.

**References**

1 Institute of Medicine. (2004). Insuring America's Health: Principles and Recommendations. Rtrieved from: .http://www.iom.edu/Reports/2004/Insuring-Americas-Health-Principles-and-Recommendations.aspx

2 Congressional Budget Office. (2012). Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Retrieved from: http://www.cbo.gov/publication/43472

3 US Census Bureau. (2012). State and County Quick facts. Rtrieved from: http://quickfacts.census.gov/qfd/states/41000.html

4 DeVoe, J. E., Dodoo, M. S., Phillips Jr, R. L., & Green, L. A. (2005). Graham Center One-Pager# 40: Who will have health insurance in 2025? November 2005. Reprinted in. *American Family Physician*, *72*, 10-15.

5 Kaiser Family Foundation. (2012). Fast facts. Retrieved from: http://facts.kff.org/results.aspx?view=slides&topic=3

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

7 OECD. (2012). Health Data. Retrieved from: http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm#

8 Associated Press. 2013. Smokers face stiff penalties under health care reform. The Oregonian.

January 24, 2013. Retrieved from: http://www.oregonlive.com/today/index.ssf/2013/01/smokers_face_stiff_penalties_u.html

9 Himmelstein, D. U., Thorne, D., Warren, E., & Woolhandler, S. (2009). Medical bankruptcy in the United States, 2007: results of a national study. *The American journal of medicine*, *122*(8), 741-746.

10 United States Courts. (2012). Bankruptcy Statistics. Retrieved from: http://www.uscourts.gov/uscourts/Statistics/BankruptcyStatistics/BankruptcyFilings/2012/1212_f2.pdf

11 . Himmelstein, D. U., Thorne, D., & Woolhandler, S. (2011). Medical bankruptcy in Massachusetts: has health reform made a difference?. *The American journal of medicine*, *124*(3), 224-228.

12 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2011). National Health Expenditure Projections 2011-2021. Retrieved from : http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

13 http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html?_r=0

14 OECD. (2012). Health Data. Retrieved from: http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm#

15 Woolhandler, S., Campbell, T., & Himmelstein, D. U. (2003). Costs of health care administration in the United States and Canada. *New England Journal of Medicine*, *349*(8), 768-775.

16 http://www.oregonlive.com/health/index.ssf/2013/03/oregons_ambitious_health_insur.html

17 Day, B., Nardin, R. (2011). The Massachussetts Model of Health Reform in Practice and the Future of National Health Reform. MassCare. Retrieved from: http://masscare.org/wp-content/uploads/2011/11/masshealthreforminpracticefinal.pdf

18 Wilemon, T. (2011, December 27). High-deductible health plans on the rise. The Tennessean.

19 Kullgren, J. T., Galbraith, A. A., Hinrichsen, V. L., Miroshnik, I., Penfold, R. B., Rosenthal, M. B., ... & Lieu, T. A. (2010). Health care use and decision making among lower-income families in high-deductible health plans. *Archives of internal medicine*, *170*(21), 1918.

20 Guy Jr, G. P. (2010). The effects of cost sharing on access to care among childless adults. *Health Services Research*, *45*(6p1), 1720-1739.

21 Li, X., & Anis, A. H. (2013). Cost sharing of prescription drugs and demand for health-care utilization among seniors with rheumatoid arthritis. *Applied Economics Letters*, *20*(1), 23-27.

22 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.

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

24 Bisgaier, J., & Rhodes, K. V. (2011). Auditing access to specialty care for children with public insurance. *New England Journal of Medicine*, *364*(24), 2324-2333.

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