

Objectives, Accomplishments & Costs of The Affordable Care Act

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Foreword: A Glance at 2017 & Beyond	<p>Currently, the long-term future of Obamacare is unclear, as President-elect Donald Trump has claimed, "Either Obamacare will be amended, or repealed and replaced." However, Trump has expressed support for several integral parts of Obamacare, including the provision preventing discrimination based on pre-existing conditions and the provision permitting young adults under age 26 to receive coverage under their parents insurance plans.³¹ Before any legislation is passed to amend or repeal Obamacare, it will remain in place. In the immediate future, Obamacare premium rates are set to rise dramatically in 2017 (though most consumers covered by Obamacare receive federal subsidies, shielding them from imminent premium cost hikes). Those covered by Obamacare's benchmark silver plan will face rate increases of 22% on average in 2017, marking a steep rise from the 7.2% average rate increase in 2016.²² Beginning in 2011, premium increases of 10% or more could be approved by any individual state with an effective rate review program, essentially granting each state the power to control premium increases.³⁵ A number of states are allowing premium increases over 10% in 2017, such as Arizona, where rates for the silver plan are set to skyrocket by an astounding 116%.²² Rising premium rates can be attributed to a number of factors, such as the escalating prices of prescription drugs, the expiration of a program in which the federal government reimbursed insurance providers for enrollees that costed the provider more than expected, and a lack of insurance options caused by insurance providers that have stopped offering coverage in numerous state marketplaces.¹²</p>		
	<u>Before the Affordable Care Act</u>	<u>The Affordable Care Act: Reforms Implemented</u>	<u>Results: Accomplishments & Costs</u>
Coverage Overview	In 2007, two-thirds of working age adults lacked insurance for a time, were paying medical bills beyond their financial capacity, or didn't get needed medical care due to costs. ³⁸	On March 23, 2010, President Barack Obama signs the Affordable Care Act. The law implements comprehensive reforms to the American health care system, and is the most important health care legislation since the creation of Medicare and Medicaid in 1965. ²⁴	The rate of uninsured Americans dropped from approximately 16% uninsured in 2010 to 9.1% by 2015. As of February 22, 2016, about 20 million people have gained coverage as a direct result of the Affordable Care Act. ²⁴
Insurance Exchange	In 2010, 83.7% of Americans were insured and 16.3% were uninsured. About 55.3% of Americans were covered by employment-based insurance, while 31.2% were covered by a government health plan. Other insured Americans received coverage from direct purchase insurance plans and various other private insurance plans. ⁴²	The National Health Insurance Exchange was created. In this marketplace, all participating insurers must offer plans to all applicants. ³⁸	As of March 31, 2015, the Health Insurance Marketplace provided coverage for 10.2 million Americans. ⁴⁰ About 8 out of 10 Americans covered through the marketplace, constituting 7.7 million people, received advanced tax credits with an average value of \$263 per month. ¹⁵
Rising Premium Costs	Before the Affordable Care Act, insurance companies were able to raise premiums costs at their own discretion at any point in time. ¹⁴ US spending on healthcare increased 6.9% annually and the premium cost for people covered by individual market for over a year increased by a whopping 15%. ¹⁶ In the three years before Obama signed the reform plan into law, the cost of premiums increased 10% annually on average. ²⁰	Insurance companies must provide justification for rate increases of 10% or higher. ¹⁷ In each state, proposed rate increases of 10% or more are scrutinized and must be approved by state or federal independent experts. States with effective rate review systems can approve statewide premium increases without any federal government involvement. ³⁵	Issuer requests for rate increases of 10% or more have plummeted from 75% to 14%, saving Americans an estimated \$1 billion in the first year alone. ¹⁷ Health care rates are growing at the slowest rate recorded in the past fifty years. ¹⁶
Expanded Medicare	Over 15 million men, women, and children could not afford to purchase health insurance, but they were not eligible for Medicaid, as they made more money than the Medicare requirement dictated at the time. ¹⁰	Access and funding increased for Medicare and for The Children's Health Insurance Program. ³⁸	Between October 2013 and April 2015, over 12.3 million people were able to sign up for Medicaid. The Affordable Care Act has allowed 28 states and Washington D.C. to expand Medicare in the same time frame. ⁴⁰
Uninsured Minors	In 2010, 7.8% of Americans under age 18 were not covered by health insurance. ²¹	A provision included in the Affordable Care Act allows young adults to receive coverage from their parents' insurance until age 26. ²¹	This provision has allowed 2.3 million young adults to gain coverage. By 2015, the percentage of uninsured Americans under age 18 fell from 7.8% in 2010 to only 4.5%. ²¹
Preventative Services	Before the Affordable Care Act came into effect, many Americans had to pay out-of-pocket for key preventative services under their health insurance. ¹ People covered by original Medicare had to pay 20% of the cost of preventative services out of pocket. Medicare Advantage plans could charge any amount for preventative services. ³⁹	The Affordable Care Act requires coverage for recommended preventative services without cost-sharing for all non-grandfathered coverage plans. ¹	Up to 76 million American have become eligible for expanded preventative service, including 30 million women and 18 million children. In 2013, over 37 million people with Medicare received free preventative services. ¹⁷
Low-Income Subsidies	There were no federal subsidies to help people afford insurance, leaving older consumers, consumers with health issues and low-income consumers priced out of the individual market. ²³	Premium subsidies are provided under the Affordable Care Act on a sliding-scale based on income, allowing low-income individuals to obtain coverage. ³⁸	As of February 2014, about 83% of the 4.2 million people who selected a plan through the marketplace were eligible for premium subsidies. An estimated 21% of individuals eligible for premium subsidies applied for coverage assistance. ⁷
Employer Mandate	Before the individual mandate took effect during the 2015-2016 enrollment period, employers were not required to offer health insurance or contribute to employees coverage costs. ²⁶	Large companies are required to offer coverage or contribute to the cost of health insurance (small businesses are exempt from the employer mandate). If employers do not comply with the individual mandate, they must pay a monetary penalty. ⁴³	From September 2013 to March 2014, the uninsured rate dropped from 20.5% to 15.8% as 9.3 million people obtained health insurance. The primary reason for the increase in coverage was a boost in people purchasing employment-sponsored insurance plans, as 8.2 million people began receiving insurance through an employer. ⁶
Lifetime Cap	In 2009, most health insurance plans imposed a yearly limit or lifetime cap on the amount of care they would cover, as nearly 60% of people covered by employer-based plans and 90% of consumers purchasing coverage on the individual market had a lifetime limit on their coverage. Approximately 20,000 people reached their lifetime cap each year. ¹	The Affordable Care Act makes lifetime caps illegal in the large group, small group, and individual markets for health insurance. The law also imposed a minimum cap that companies could charge from 2011 to the end of 2013, before coverage plans with price caps were entirely prohibited on January 1st, 2014. ¹	An estimated 105 million Americans saw a lifetime limit on their health insurance coverage removed. ¹

Pre-Existing Conditions & Dropped Coverage	<p>A survey conducted in 2009 revealed that 36% of Americans who attempted to purchase coverage directly from an insurer were turned down, charged more, or received coverage that excluded a specific pre-existing health issue.¹ Insurance companies could deny coverage to anyone, including minors, and individuals who become sick were at risk of getting dropped by their insurance provider.³²</p>	<p>As of 2014, no insurance plan can reject someone, charge them more, or refuse to pay essential health benefits for any pre-existing condition. People receiving coverage cannot have their rates inflated or be lose coverage due to their health status.¹⁷ Before 2014, Obama used the Pre-Existing Condition Insurance Program to serve as a bridge in coverage for high-risk individuals.¹</p>	<p>As many as 129 million Americans with pre-existing conditions, including about 17 million children, are no longer at risk of being denied coverage because of their conditions.¹</p>
Essential Health Benefits	<p>Private Medicare Plans, also called Medicare Advantage Plans, could require beneficiaries to pay more out of pocket for specific services than those with Original Medicare plans.³⁹</p>	<p>Mandatory coverage is provided for a pre-determined list of core health services. Medicare advantage plans must provide all the same benefits as Original Medicare plans, and Medicare Advantage plans cannot charge more than Original Medicare plans for specific services like chemotherapy and dialysis.³⁹ This provision extends coverage to numerous pre-existing conditions that may not have been covered in the past, such as pregnancy, mental health illnesses and substance abuse disorder.¹⁷ Consumers' essential health benefits are protected by an out-of-pocket maximum, insuring core health services are available to everyone.¹</p>	<p>The Department of Health and Human Services estimates the essential health benefits policy will allow 8.7 million Americans to receive maternity coverage, 2.3 million Americans to receive mental health coverage and 1.3 million Americans to receive prescription drug benefits.¹</p>
Individual Mandate	<p>Before the individual mandate took effect on January 1st, 2014, Americans had never faced any direct fiscal expense for lacking health insurance.²⁷</p>	<p>The individual mandate requires everyone to obtain either a minimum essential coverage plan or apply for and receive an exemption from the government. The monthly Obamacare fee for lacking insurance is derived from an individual's income and family size, and the penalty increases every year for those who opt to forgo insurance for an extended period of time.²⁷</p>	<p>The ObamaCare penalty for lacking coverage impacted about six million people when it took effect in 2014. Initially, the cost of being uninsured was a maximum of \$285 per family, or 1% of income, whichever figure was greater. The 2014 escalating fees for single adults without coverage was \$95, \$325, and \$695. In 2015, the fee increased to \$975, or 2% of income, and this year, uninsured families may pay as much as \$2,085, or 2.5% of income, whichever amount is greater.²⁸</p>
Small Business Support	<p>Historically, premium costs to small businesses were far more consequential to small business owners than the cost of premiums to large-scale organizations with a sizable scales of operation. Despite the difference in the opportunity cost of premiums, large companies and small businesses often received the same benefits, putting small businesses at a severe disadvantage.¹</p>	<p>The Affordable Care Act created a tax credit for business owners that provide average wages under \$50,000, employ less than 25 workers, and contribute at least half the cost of each employees' insurance premium. As of 2014, the small business tax credit is typically reserved for employers who purchase coverage through the Small Business Health Options Marketplace.¹ This marketplace was introduced by the Affordable Care Act for small business owners who required lower-priced group plans and tax credits in order to contribute to their employees' coverage costs. Through this medium, employers can receive tax breaks of up to 50% on the costs of their employees' insurance plans.³³</p>	<p>The Small Business Health Options Marketplace became available in 2014 to employers who met a set of guidelines; these employers had to cover at least half the cost of employees' health care, provide average annual wages below \$50,000, and employ by no more than 25 full time workers. According to a report published in May 2015 by The Centers for Medicare and Medicaid, the Small Business Health Options Marketplace provided coverage for 85,000 people working for 10,700 small employers.³⁴</p>
Medical Loss Ratio	<p>Before 2011, insurance companies could spend a significant portion of consumers' premium dollars on anything they wanted to with no restrictions. Health insurance providers frequently directed premium dollars to administrative costs, marketing, overhead, or executive salaries.¹</p>	<p>The Affordable Care Act requires insurance companies to spend at least 80% of the premiums they collect on clinical services and other consumer-oriented directives. If an insurer fails to meet the minimum proportional obligation, they are required to issue rebates to enrollees.¹</p>	<p>Since this policy was introduced, consumers have saved an estimated \$9 billion. The medical loss ratio requirement has pushed insurance companies to charge lower premiums and operate more efficiently. Furthermore, consumers have received over \$1.9 billion in rebates because of the medical loss ratio provision.¹</p>
Combatting Insurance Fraud	<p>To identify and fight insurance fraud before the Affordable Care Act, the Department of Health and Human Services employed a "pay and chase" strategy in which the government typically paid for fraudulent claims before attempting to prosecute wrongdoers and recoup fraudulent payments. In 2008, the government recovered fraudulent Medicare payments totaling \$2.14 billion.³⁹ Nonetheless, it was estimated in 2010 that health insurance fraud cost as much as \$100 billion each year.¹⁸</p>	<p>Rather than attempting to catch perpetrators after the fact, the Affordable Care Act aims to prevent fraud before it can occur by utilizing more intensive screening practices and improving coordination across all levels of government.³⁹ Additionally, the law includes harsher legal punishments for those who participate in insurance fraud. To insure the success of these provisions, the Health Care Fraud and Abuse Control Account contributed \$350 million over ten years to support fraud-fighting efforts.³⁰</p>	<p>Under the Affordable Care Act, fraud recovery efforts have been more successful than ever before. Immediately after the anti-fraud provisions went into effect, the government recovered a shocking \$4.1 billion in 2011, and reports of lofty fraud recovery figures continued in subsequent year.³⁹ During the 2012 and 2013 fiscal years, the government recovered \$4.2 billion and \$4.3 billion, respectively. As a result, the Health Care Fraud and Abuse Control Program reported its highest return on investment for a three year period from 2011 to 2014. During this time frame, each dollar spent to combat fraud resulted in the recovery of \$8.10.¹¹</p>
Readmission Rates	<p>Medicare payments to health services providers neglected to evaluate the quality of care that providers offered their patients.³⁹ As a result, almost one in five Medicare enrollees were readmitted to a hospital less than 30 days after they had been initially discharged.¹ The estimated annual cost of hospital readmissions was reported as more than \$26 billion.¹⁷</p>	<p>To evaluate the quality of care provided by different institutions, the Affordable Care Act contains a provision that has established the practice of reviewing each individual hospital's readmission rates. Because hospitals with high readmission rates receive lower Medicare payments, there is greater incentive for hospitals to provide superior care so that patients will not have to return after being discharged.¹</p>	<p>From 2007 to 2011, the Medicare all-cause 30-day readmission rate was consistently reported at 19%. In 2012, this figure fell to 18.5% before dropping again in 2013 to 17.5%.¹ This change signifies an 8% decline in hospital readmissions, meaning that from January 2012 to December 2013, approximately 150,000 fewer Medicare enrollees were readmitted to hospitals than in prior years.¹⁷</p>

Hospitals and other health services providers often operated with considerable independence from one another. This lack of coordination resulted in unnecessary and preventable costs, and before the Affordable Care Act, there was no Medicare-related incentive for health services providers to improve care coordination.¹

To increase coordination between doctors, hospitals, and other health services providers, Affordable Care Organizations were established under the Affordable Care Act. Each Affordable Care Organization is comprised of a network of health services providers that work together to offer patients a more integrated care system. The law provides incentives for Affordable Care Organizations to reduce spending and meet performance standards based on the level of quality they provide to patients.³⁹ The Shared Savings Program financially rewards health services companies that participate in or create an Affordable Care Organization.¹

In the first four years of their existence, Affordable Care Organizations saved an estimated \$940 million.¹² Health services providers that entered the program in 2012 recorded improved care on 30 of 33 quality measures. When compared with group practices, Affordable Care Organization participants provided better quality care on 17 out of 22 measures. In 2015, 7.2 million patients were served by the 405 Affordable Care Organizations participating in the Shared Savings Program.¹

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