HEALTH POLICY REPORT

The Affordable Care Act at 10 Years — Its Coverage and Access Provisions

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The Affordable Care Act (ACA), known colloquially as Obamacare, is almost certainly one of the most consequential — and controversial — pieces of enacted health care legislation in U.S. history. To the delight of some observers and the consternation of others, the ACA has now survived 10 years since it was signed into law on March 23, 2010, by an exultant President Barack Obama.

The 10-year mark is an appropriate time to look back on the ACA and take stock of its evolution, accomplishments, and shortfalls. We approach this task in two Health Policy Reports now published in the *Journal*; the current report reviews the coverage and access provisions of the law, and the second reviews the provisions of the law that are aimed at reforming the health care delivery system.[1] Both articles discuss relevant elements of the legislation, their implementation, and their discernible effects on health coverage, access to care, and the quality and costs of services.

As a preview, the following overall conclusions concerning the ACA seem justified. First, its implementation has taken major unexpected twists and turns, especially with respect to coverage and access provisions. Second, the implementation of the law has been deeply affected by partisan conflict that has prevented subsequent adjustments and improvements that Congress typically makes after passage of major legislation in any policy realm. Third, although critics sometimes portray the ACA as a federal takeover of the health system, considerable discretion has been given to states, with the result that there is variability in how the law has affected their populations. Fourth, the ACA has had well-documented effects on levels of insurance coverage in the United States, reducing the numbers of uninsured persons to historically low levels and facilitating increased access to health care services, especially among low-income persons and persons of color. Fifth, the effects of the law on the cost and quality of health care services are difficult to disentangle from the complex, evolving tapestry that is our health system.

CORE PROVISIONS AND THEIR IMPLEMENTATION

The coverage and access provisions of the original law can be roughly grouped into two broad categories. The first involves direct federal subsidies to increase the number of Americans with affordable, high-quality health insurance, and the second involves reforms of the individual health insurance market to make it possible for persons without other sources of coverage, including those with preexisting conditions, to obtain health insurance.

INCREASING THE NUMBER OF INSURED AMERICANS THROUGH FEDERAL SUBSIDIES

Medicaid Expansion

The ACA has considerably expanded the number of Americans who are eligible for Medicaid and has made eligibility contingent on income, rather than on individual factors such as pregnancy, age, or disability. Through a system of incentives and penalties, the ACA essentially requires states to cover all residents with incomes that are at or below 138% of the federal poverty level ($35,535 for a family of four). As an incentive to expand Medicaid, the federal government covers 100% of the cost for the first 3 years, tapering to 90% by 2020. For the traditional Medicaid population, the federal government covers an average of 61% of the bill. States that do not comply with the requirements of the law risk losing federal Medicaid funds for existing populations.

On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the Supreme Court ruled

that the threat by the federal government to terminate Medicaid funding for noncompliant states was unconstitutionally coercive, effectively rendering the Medicaid expansion optional for states.[2] As a result of the ruling, 14 states with Republican leadership still have not expanded Medicaid. Another consequence of the ruling is that in states that have not expanded Medicaid, persons with incomes below 100% of the federal poverty level (but who are ineligible under the restrictive income standards for Medicaid in some states) have no access to federal assistance for health insurance. Assuming these persons would be covered by Medicaid, the ACA made them ineligible for the private insurance subsidies described below. This is one of many unanticipated incongruities in the implementation of the law that might have been addressed if partisan conflict had not frozen the law in place.

Prompted by ballot initiatives, several states have taken up expansion despite political opposition. Idaho and Utah expanded Medicaid in early 2020, and Nebraska is scheduled to move forward later this year. Several other states are considering ballot initiatives to expand Medicaid. A deal reached in January between the Democratic governor and the Republican leader of the state Senate in Kansas makes it likely that Kansas will expand its Medicaid program this year.

Using its waiver authority, the federal government has granted states discretion in how they expand Medicaid. The Obama administration approved waivers in seven Republican-led states, allowing experimentation with conservative ideas such as health savings accounts. The Trump administration went further, permitting nine states to impose work requirements as a condition for Medicaid coverage, although these requirements in three states have been blocked by federal courts and no state currently has a work requirement in place.

Subsidies for Individual Private Insurance

In addition to expanding Medicaid, the ACA subsidizes the purchase of private insurance for persons without access to employer coverage or public programs. Before the ACA, several factors made it challenging for persons in many states to obtain coverage in the individual market.

Premiums were often high to account for sicker-than-average clients. Individual policies tended to have higher administrative costs than group policies. In the individual market (unlike employer plans), purchasers lacked assistance with the premium costs. Finally, insurers often declined to cover persons with preexisting health conditions.

To address these problems, the ACA subsidizes the purchase of individual insurance in newly created private individual insurance "marketplaces." Premium subsidies are available to persons with incomes at or below 400% of the federal poverty level ($103,000 for a family of four) and ensure that buyers spend no more than a fixed percentage of their income (ranging from 2.06% for the poorest to 9.78% for the wealthiest) on health insurance. The amount of the subsidy is based on the cost of a moderately generous plan in the person's local insurance market (i.e., a plan that covers approximately 70% of the expected costs for the insured person).

The ACA also recognized that just having private insurance might not ensure access to needed care among lower-income Americans. For that reason, in addition to premium subsidies, the law provides that the federal government will subsidize private insurers to provide cost-sharing assistance for persons with incomes of 100 to 250% of the federal poverty level ($25,750 to $64,375 for a family of four). With this assistance, a moderately generous plan covers up to 94% of the expected costs for an insured person.

Like other aspects of the ACA, these cost-sharing payments have been subject to litigation.[3] In 2016, a federal judge ruled that the government could not help plans with the cost of providing assistance with cost sharing. However, the ruling did not relieve insurers of the obligation to offer this more generous coverage according to the law. Most states responded with successful workarounds that blunted the effect of the ruling.

REFORMING INSURANCE MARKETS

In addition to premium subsidies and cost-sharing assistance, the ACA included an interlocking series of insurance reforms to address fundamental problems with the individual insurance market — such as discrimination against persons with preexisting health conditions and a lack of transparency regarding covered benefits.

First, the ACA required insurers to accept all applicants, irrespective of health status (referred to as "guaranteed issue") and to renew coverage for those wishing to continue it (known as "guaranteed renewal"). Moreover, plans could no longer charge persons with health conditions a higher premium or exclude health services they might need. Premiums could vary only according to age, family size, geographic location, and smoking status. Medical underwriting, which required applicants to undergo physical examinations and even laboratory testing before being approved for coverage, was banned. Plans were also required to cover 10 categories of essential health benefits that were similar to those available under employer plans.

Second, the ACA imposed an individual mandate — a requirement that all Americans have or purchase health insurance or pay a tax penalty. The purpose of the mandate was to ensure that healthy persons purchased insurance so as to create balanced and stable risk pools, making it financially feasible for insurers to cover persons with preexisting conditions at regulated rates. Otherwise, it was feared that a disproportionate number of sick persons would enroll, and their expenses would drive up premiums such that only the sickest persons would buy insurance.

The government mandate to have health coverage was — and still is — the most contested aspect of the ACA. The Supreme Court upheld the constitutionality of the mandate in 2012 as an exercise of the taxing authority of the government. However, the tax penalty was subsequently repealed by a Republican Congress in 2017.[4]

Following this congressional action, 18 Republican states challenged the constitutionality of the ACA on the grounds that the mandate could no longer be considered a tax, rendering it unconstitutional. They argued further that the mandate and tax provisions were inextricably linked to the rest of the law, making the ACA unconstitutional in its entirety. A federal district court judge in Texas agreed with this argument. In December, an appeals court upheld the ruling but asked the lower court to reconsider its sweeping assertion that voiding the mandate rendered the entire law unconstitutional.[5] Regardless of the outcome, the decision will be appealed to the Supreme Court. Six states have reacted by imposing their own mandates.

A third reform of individual insurance markets involved the creation of marketplaces (sometimes called "exchanges") designed to make the purchase of insurance easier for consumers and to foster competition among plans. Marketplaces are Web-based tools designed to list insurance policies for sale in a particular area in a way that makes shopping and comparing benefits and premiums easy for consumers.

States had the option to build their own marketplace or rely on a federal website. A total of 39 states use the federal platform healthcare.gov, and the rest have established their own websites. When healthcare.gov was launched in October 2013, the system famously crashed, but the Obama administration was able to get the system functioning before the end of the first open-enrollment period.

Although the ACA market reforms focused mainly on individual insurance, several provisions also applied to employer plans, including a requirement to cover certain preventive services without cost sharing, bans on lifetime and annual limits on coverage, and a maximum 90-day waiting period for enrollment. In addition, one of the most popular provisions of the law required that all private insurers offer coverage to dependent young adults up to 26 years of age on their parents' plans.

EFFECTS OF COVERAGE EXPANSIONS AND REFORMS

EFFECTS ON INSURANCE COVERAGE

In 2010, a total of 48.6 million persons lacked health insurance.[6] The Congressional Budget Office (CBO) projected that the ACA would lower the number of uninsured persons to 23 million by 2019.[7] After the 2012 Supreme Court decision and other changes, the CBO revised that estimate to up to 29 million persons.[8,9]

The actual effects of the law have been mostly consistent with these revised expectations (Fig. 1). By 2016, the number of uninsured persons had decreased to a low of 28.6 million, but it has since increased to 30.4 million.[6] The newly covered groups have differed somewhat from expected. Although the CBO had projected that employers would drop coverage given the availability of subsidized individual insurance, employer coverage has remained largely the same. Con-

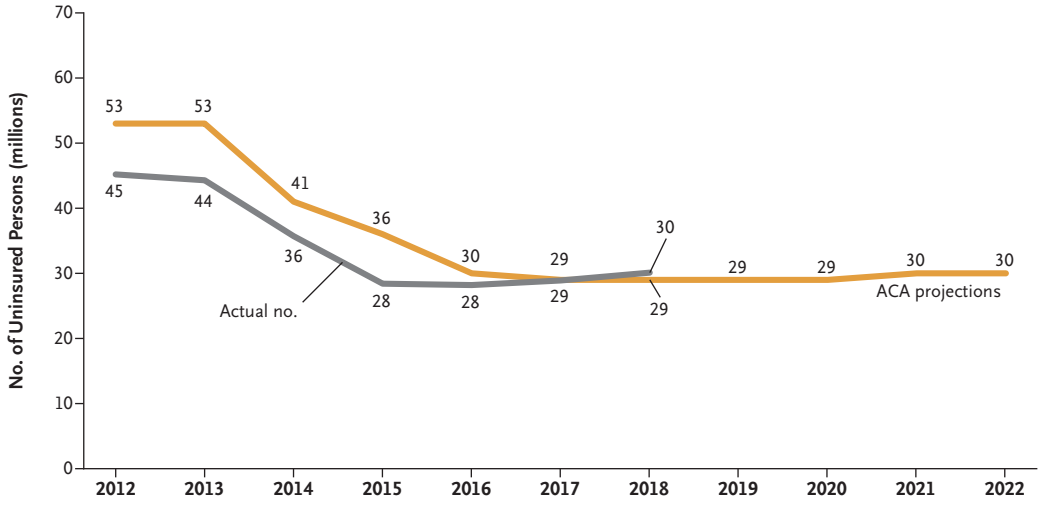

Figure 1. Projected and Actual Numbers of Uninsured Adults Younger than 65 Years of Age after Implementation of the Affordable Care Act.

Shown are revised projections of the number of uninsured persons after the implementation of the Affordable Care Act (ACA), according to the Congressional Budget Office (ACA projections), as well as the actual number of uninsured persons over time, according to data from the National Center for Health Statistics. The dependent-coverage provision went into effect in September 2010. The major coverage expansions went into effect in January 2014; these include Medicaid expansion, marketplaces and subsidies, and the individual-mandate penalty.

sequently, marketplace enrollment was lower than projected. Medicaid enrollment, however, exceeded projections.

Medicaid

New enrollment in Medicaid accounted for more than half of coverage gains since enactment of the law.[10] Expansion resulted in 12 million new enrollees, but outreach also brought into the program more persons who had previously been eligible, including approximately 1.7 million persons in states that did not have expansion.[11] This so-called "welcome mat" effect across all states is estimated to have accounted for 29% of the decrease in the uninsured rate between 2014 and 2015, the year of the largest coverage gains from the ACA.[10,12,13] An estimated 2.5 million persons are uninsured because they fall into the coverage gap in the 14 states that have not expanded Medicaid.[14]

Marketplaces

Nearly half the gains in insurance coverage have resulted from enrollment through ACA marketplaces, in which premium subsidies have played the most important role.[10] Of the 10.6 million persons enrolled in marketplace plans in 2019, a total of 87% received such assistance.[15]

Together with cost-sharing reductions, subsidies have substantially lowered the amounts that recipients spend on premiums and deductibles. In 2019, the average monthly premium across all state marketplaces was $594, but subsidies resulted in a net average monthly cost of $80.[15] The cost-sharing subsidies reduced the average deductible in a moderately generous plan from $4,375 to $239 for persons with incomes between 100 and 150% of the federal poverty level.[16]

Individual market reforms, such as bans on exclusions for preexisting conditions, may also have spurred enrollment. In 2010, only one third of persons with preexisting conditions who had sought coverage in the individual market obtained insurance. By 2016, a total of 60% of persons with preexisting conditions who had looked for coverage in the individual market during the previous 3 years ended up buying a plan.[17]

Yet, although these market reforms and subsidies enabled persons across the income spectrum to buy insurance on their own, those with incomes above the subsidy cutoff point have

faced substantial financial barriers to coverage. In 2019, the average premium of the least generous marketplace plan for a 40-year-old person with an annual income of $49,000 exceeded 10% of the income level in 24 states.[18]

Dependent Coverage

The dependent-coverage provision of the ACA went into effect 6 months after the law passed, triggering an immediate decrease in the uninsured rate among persons who were 19 to 25 years of age.[6] More than one third of adults younger than 26 years of age were uninsured in 2010, the highest proportion in any age group. By 2013, that percentage had decreased to 26.5%. As Medicaid expansion and marketplaces later took effect, the percentage of young adults who were uninsured decreased to 15%.

Mandate Repeal and Administration Actions

Congressional and executive branch actions after the 2016 election have reversed some of the coverage gains of the ACA. However, these measures have had less effect than expected. This is probably because the critical coverage provisions of the law — Medicaid expansion, marketplace subsidies, and market reforms — have remained intact after the failure of Congress to repeal the ACA in 2017.

Elimination of the mandate penalty is estimated to have lowered insurance coverage across all sources by approximately 1 million persons in 2018.[11] Over the next decade, the CBO projects that 7 million fewer persons will have coverage because of its repeal.

The Trump administration has also compromised the stability of insurance markets by lifting Obama-era restrictions on health plans that do not comply with the ACA, including preexisting-condition protections. These non–ACA-compliant plans include, for example, policies that are purchased to fill short-term coverage gaps. Although there is evidence of aggressive marketing of noncompliant plans,[19,20] they are not projected to grow substantially, perhaps because premium subsidies cannot be used to purchase these plans.

The Medicaid waiver initiatives of the Trump administration, such as allowing work requirements, are another risk to coverage. In Arkansas, between October and December 2018, a total of 17,000 Medicaid beneficiaries, most of whom were working but were unaware of the need to inform the Medicaid authorities or did not fill out forms correctly, lost Medicaid as a result of the state's work requirement before a federal district judge blocked it.[21]

COSTS TO THE FEDERAL GOVERNMENT

The cost to the federal government of the Medicaid expansion and marketplace subsidies and reforms was $128 billion in 2019 — considerably less than the $172 originally projected by the CBO.[7,11] This is a result of lower growth in health care costs generally, lower premiums in the marketplaces, and lower enrollment in the marketplaces.[22] Over the next 10 years, the total cost of these provisions is projected to be $1.7 trillion.[11]

EFFECTS ON ACCESS TO CARE

Increases in the number of insured Americans have been associated with improved access to care and greater use of health services. Utilization of primary and specialty care services and access to prescription drugs have been higher among low-income adults in Medicaid expansion states than in nonexpansion states.[13] Marketplace subsidies have also reduced cost-related barriers to needed care and increased the likelihood that enrolled persons will have a usual source of care.[10] The dependent-coverage provisions have also led to more young adults having a usual source of care and have increased the use of needed specialty mental health services.[23]

EFFECTS ON FINANCIAL PROTECTION

Studies indicate that the Medicaid expansion, marketplace subsidies,[24] and dependent-coverage[25] provisions all have led to decreases in out-of-pocket costs among enrolled persons. These reductions in cost exposure have led to improvements in overall financial well-being. Medicaid expansion is also associated with reductions in reports of problems paying medical bills.[26]

EFFECTS ON HEALTH

Thus far, the published findings on the effects of the ACA on health outcomes are more mixed. Most studies that have examined the health effects of the ACA have compared Medicaid nonexpansion states with expansion states. Medicaid expansion has been associated with reductions in mortality from cardiovascular causes among middle-aged adults[27] and in mortality from end-stage renal disease at 1 year.[28]

Two recent working papers from the National Bureau of Economic Research also suggest reductions in mortality as a result of the coverage expansions. Miller et al. found a reduction in all-cause mortality among low-income adults who were 55 to 64 years of age in states with Medicaid expansion. This reduction resulted in an estimated 19,200 fewer deaths in this age group over the 2014–2017 period.[29] The authors estimated that decisions by states not to expand Medicaid resulted in 15,600 avoidable deaths.

Goldin et al. found that in a group of randomly selected persons who had paid a tax penalty for not buying insurance, a letter from the Internal Revenue Service reminding them that they could avoid the penalty by getting coverage resulted in increased insurance coverage and one fewer death for every 1648 persons contacted.[30] However, in other areas, such as birth outcomes, the research is less definitive, with some studies showing reductions in infant mortality[31] and others showing no change in measures such as birth weight.[32] A confident assessment of the health effects of insurance expansions may well take much longer than an assessment of their more immediate effects on coverage, access, and financial burden.

CONCLUSIONS

Despite a fractious legislative path to enactment and a similarly contested rollout, the ACA has had well-documented effects in reducing the percentage of uninsured Americans to historically low levels. Available studies also show an association between obtaining health insurance under the ACA and improved access to care, reduced financial burden, and possibly improvement in health status among affected populations. These positive effects of insurance expansion are consistent with literature from the pre-ACA period that, for the most part, showed that health insurance reduces financial stress and improves health status over time.[33,34] Nevertheless, these gains have come at a financial cost, and proponents and critics of the ACA clearly differ on whether the benefits of the law justify its expenditures to date.

This is one reason that the future of the ACA remains far from certain. Efforts to roll back key provisions of the ACA or comprehensively invalidate it persist and are taking a toll. Most notable is the challenge to the constitutionality of the law; this challenge is currently making its way through the courts. A final decision, perhaps by the Supreme Court, may or may not come before the 2020 election. An ultimate ruling by the Court that the ACA is unconstitutional in its entirety would substantially disrupt a health system that has spent 10 years adapting to the ACA and could threaten the insurance status of tens of millions of Americans.[35] Since the insurance status of their patients directly influences the work of health professionals, they have a clear interest in the outcome of the fierce, continuing struggle over the future of this landmark legislation.

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