THE CENTURY FOUNDATION

FACTS HEALTH CARE

What You Need to Know about the Future of the Affordable Care Act

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In attempting to understand health care reform we must also learn to cope with the mire of bitter political dialogue framing and more often than not obscuring the facts of the issue. The Affordable Care Act (also known as Obamacare) was passed in 2010 to address a number of failures in the United States' health care system. These included:

- 23 million Americans living without health insurance
- Barriers to gaining insurance including discrimination based on preexisting conditions and lack of affordability
- The highest national spending on health care in the world

Any attempt at reform needed to address these issues; whether the potential solutions lay in the public or private sector proved to be a point of debate.

The American health care system has long been tied to employment, with employers offering insurance coverage as part of a larger benefits package. When people lack coverage during periods of under- or unemployment they tend to go longer without seeking care, given the expense of paying out-of-pocket costs for treatment. Expense is linked to this pattern of behavior, as patients are more likely to visit emergency rooms when they don't have access to primary care. The costs of emergency care are far higher, and these bills often go unpaid. This forces hospitals to write off the losses, pushing prices higher.

The framers of the ACA attempted to shift health coverage toward the public sector with the inclusion of a "public option," insurance funded by taxes and operated by the government. This "Medicare-for-all" approach quickly disappeared from reform efforts in 2009, as it became clear that the government would instead remain a provider for under sixty-five-year-olds only by encouraging patient enrollment in the private market, along with modest expansions in Medicaid.

The ACA sought to expand coverage by:

- Requiring individuals to have coverage, providing subsidies for those earning below $47,080 (400 percent the federal poverty level in 2015).
- Requiring employers of more than 250 employees to offer coverage.
- Raising the eligibility of Medicaid coverage up to $15,654 (133 percent of the federal poverty level), offering grants to states to offset the cost of expansion.

- Eliminating denials of coverage by insurance companies to those with “pre-existing conditions” and expanding access to reproductive care.

- Extending parental coverage of their children until age 26.

With more consumers in the private insurance pool, companies could theoretically offer lower premiums through private market competition.

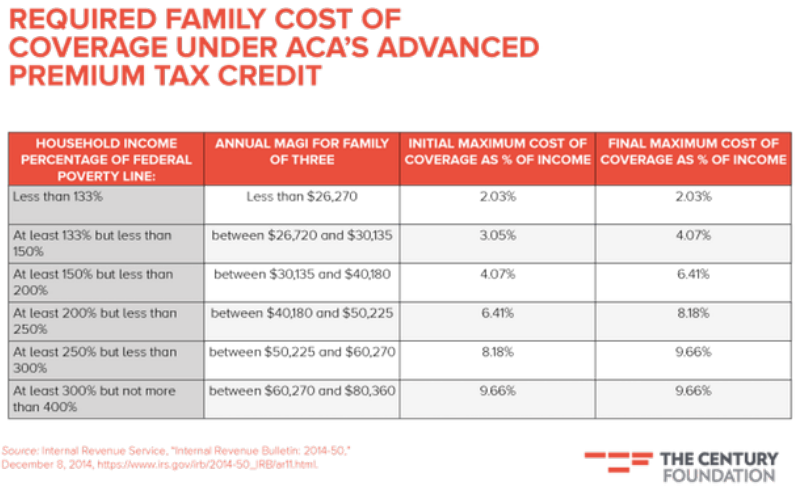
The law establishes tax penalties for employers who do not provide “adequate and affordable” coverage to their employees. Individuals also must pay a penalty if they fail to enroll in coverage, known as a “shared responsibility tax.”

It also established a number of protections for insurance companies, wary about taking on more “risky” consumers (those more likely to get sick). These included:

- Temporary Risk Corridors Program, essentially insurance for the insurance companies, paid out when claims costs exceeded a certain amount. (This expired at the end of 2014.)

- The Risk Adjustment Program, which forced companies with healthier consumers to pay into a fund which protected insurers of higher-cost patients.

- Allowance of “Translational Plans,” high premium coverage illegal under ACA guidelines, but permitted to remain in effect until 2017.



REQUIRED FAMILY COST OF COVERAGE UNDER ACA'S ADVANCED PREMIUM TAX CREDIT

HOUSEHOLD INCOME PERCENTAGE OF FEDERAL POVERTY LINE:	ANNUAL MAGI FOR FAMILY OF THREE	INITIAL MAXIMUM COST OF COVERAGE AS % OF INCOME	FINAL MAXIMUM COST OF COVERAGE AS % OF INCOME
Less than 133%	Less than $26,270	2.03%	2.03%
At least 133% but less than 150%	between $26,720 and $30,135	3.05%	4.07%
At least 150% but less than 200%	between $30,135 and $40,180	4.07%	6.41%
At least 200% but less than 250%	between $40,180 and $50,225	6.41%	8.18%
At least 250% but less than 300%	between $50,225 and $60,270	8.18%	9.66%
At least 300% but not more than 400%	between $60,270 and $80,360	9.66%	9.66%

Source: Internal Revenue Service, "Internal Revenue Bulletin: 2014-50," December 8, 2014, https://www.irs.gov/irb/2014-50_IRB/ar11.html.

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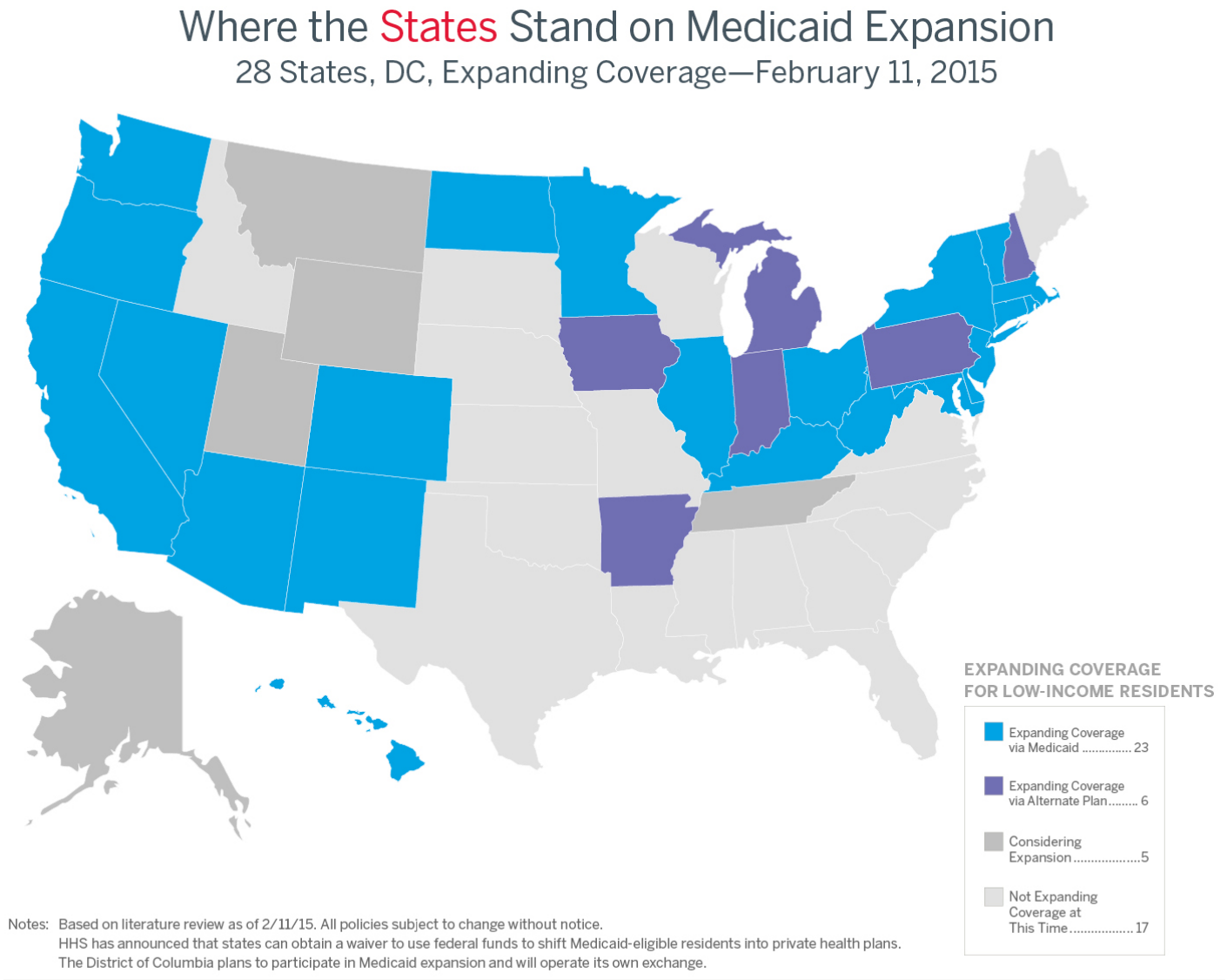
So, What Has Actually Happened?

The ACA passed in 2010, but did not go into full effect until 2015. As data begins to trickle in we can start to glimpse the law's effects. Coverage has expanded, with more than 16 million people enrolling in health insurance since the law's passage, including 5.7 million young adults under twenty-six. Health care costs have slowed as the insurance pool grows, and studies have shown that neither Medicaid expansion or employer requirements have had an impact on job losses or changes.

Important barriers to care still exist, as nineteen states have refused to expand Medicaid coverage (after a 2012 supreme court ruling struck down the federal expansion mandate), and an affordability gap still exists between the current Medicaid income cutoff and available subsidized plans.



Via: The Advisory Board Company

Subsidies also quickly begin to taper off as an individual's annual income rises above 200 percent FPL (about $23,000). The modest subsidies in this income range do little to offset the monthly premium cost of these plans (many of which include deductibles as high as $6,000 per year). This reality makes health care attainable, but hardly affordable for those not enrolled in an employer's plan.

Medicaid reimbursement from the federal to state governments will gradually taper off to 90 percent by 2020, making it less appealing for states to accept the funds. The White House estimates that by refusing to expand Medicaid, 4.9 million people will go without health insurance in 2016. These states include Texas and Florida, which contain the highest

populations in the nation that would be eligible under the new guidelines.

What's Next?

Despite the political failures to repeal the Affordable Care Act, many unresolved challenges still exist in various stages of the legal system. Most of these involve repeals of the individual mandate, the employer mandate or both. Some have proposed replacing the pre-existing condition ban with the establishment of "high-risk" pools for these patient, a cost sharing strategy that would enable higher premium costs.

A significant unresolved challenge involves the requirement of religious organizations (exempted from contraceptive coverage requirements by the Hobby Lobby decision) to report their denial of coverage, so that the federal government could intervene and provide contraceptive care. This decision would have a huge impact on the health of millions of women.

Because 2015 is the first year in which individuals and companies must pay a tax penalty for lack of coverage, the punitive effects of the mandate remain empirically unknown.

For states rejecting the Medicaid expansion, an alternative allows the use of federal funds to cover the private insurance premiums of low-income individuals. This is a clear preference of insurance companies, as well as doctors who can receive higher payments from private insurers, precisely the sort of practice contributing to escalating overall health care prices.

Ultimately, the outcome of the 2016 presidential election will have the largest impact on the fate of the ACA, as the two parties have drawn clear lines of support (and distaste) for the law. As the futures of millions of Americans hang in the balance, a new executive arm could continue the effort to broaden health care access in the U.S., or undo it.

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