The Real-World Effects of the Affordable Care Act

A Research Update

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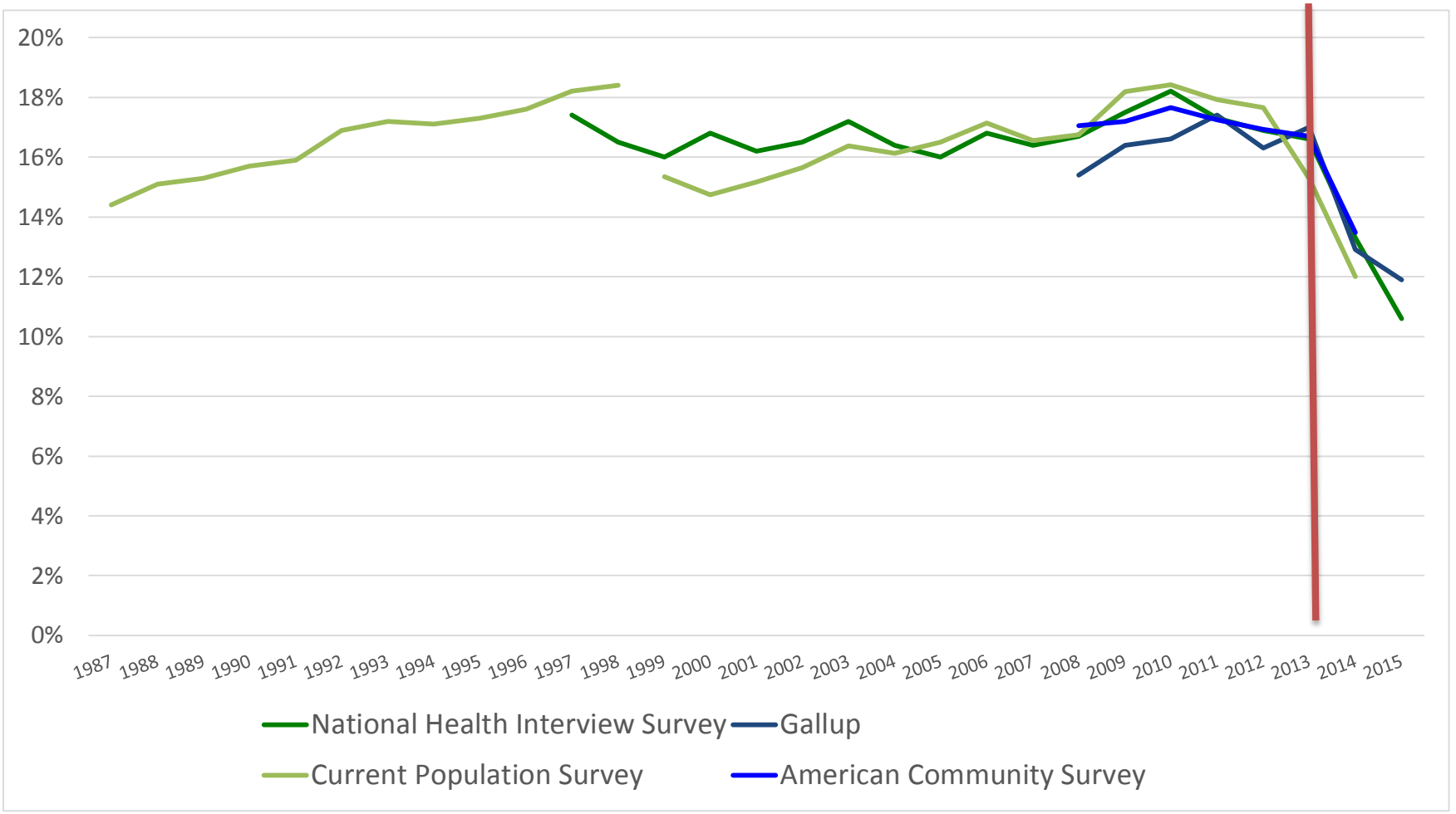
Outline for Today

- Overview of research findings on the Affordable Care Act (ACA) and Medicaid:
  - ACA effects on coverage
  - Medicaid expansion impacts on patients
  - Budget effects from Medicaid expansion
- Medicaid reform proposals
- ACA changes under the new administration

ACA & the Uninsured Rate



ACA Coverage Effects

- We attempted to disentangle ACA coverage impacts from these key features, using national survey data

1. Medicaid expansion
2. Premium subsidies
3. The individual mandate

- Study design: 'Difference-in-Difference' – pre vs. post comparison, with control groups (geography and/or income)

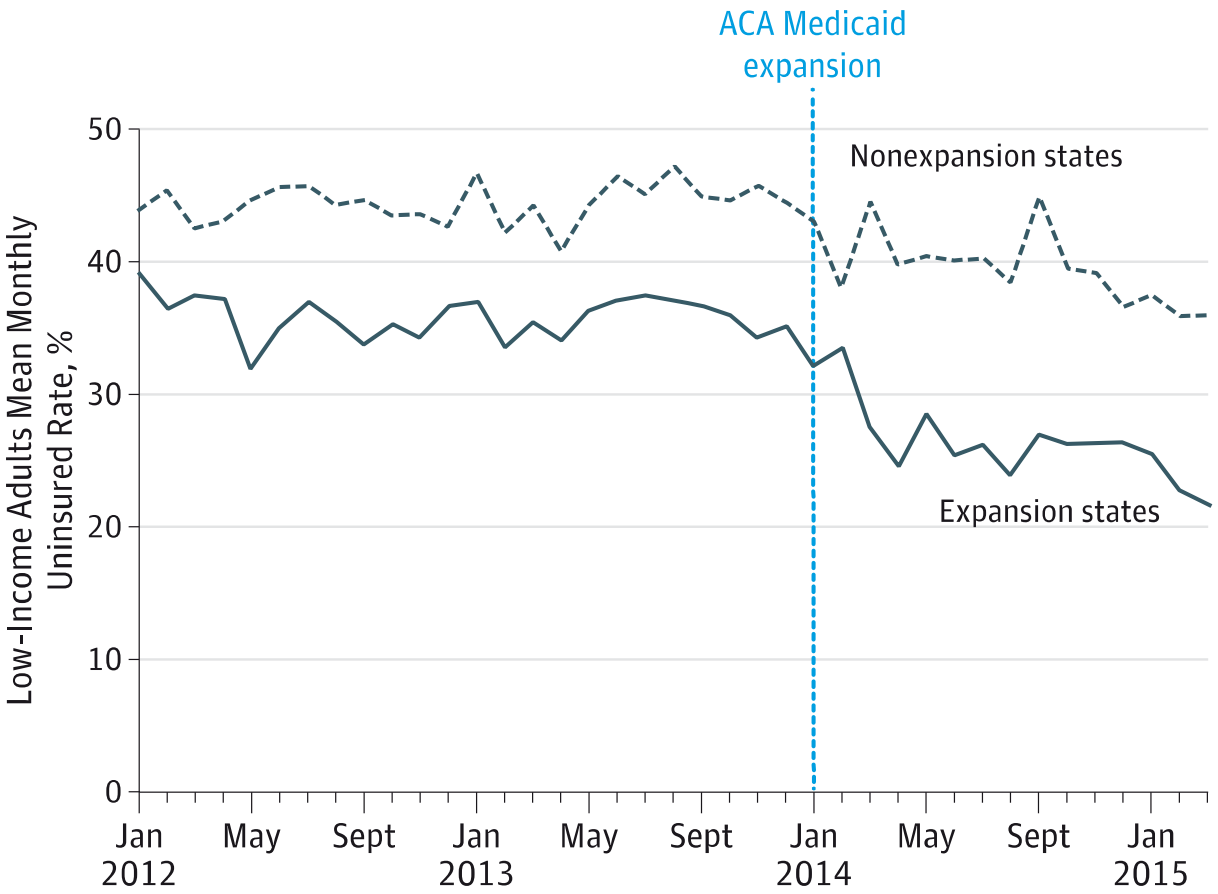
Source: *Frean, Gruber, and Sommers, JHE 2017*

Coverage: Findings

- 60% of ACA coverage gains were from **Medicaid**
  - 30% from those made newly eligible by the ACA
  - Other 30% due to "woodwork" or "welcome mat" effect for those who were already eligible but not enrolled
    - Streamlined application, navigators, and publicity
    - Includes roughly 1 million children
- 40% of ACA coverage gains were from **premium subsidies** for private insurance
- **Individual mandate** details had little effect on overall enrollment

Medicaid Expansion: Coverage

Figure 3. Uninsured Rates for Low-Income Adults in Medicaid Expansion vs Nonexpansion States



Source: *Sommers, Gunja et al., JAMA 2015*

Access to Care

"We have a higher purpose than just handing out Medicaid cards…
We will not just accept the hollow victory of numbers covered."

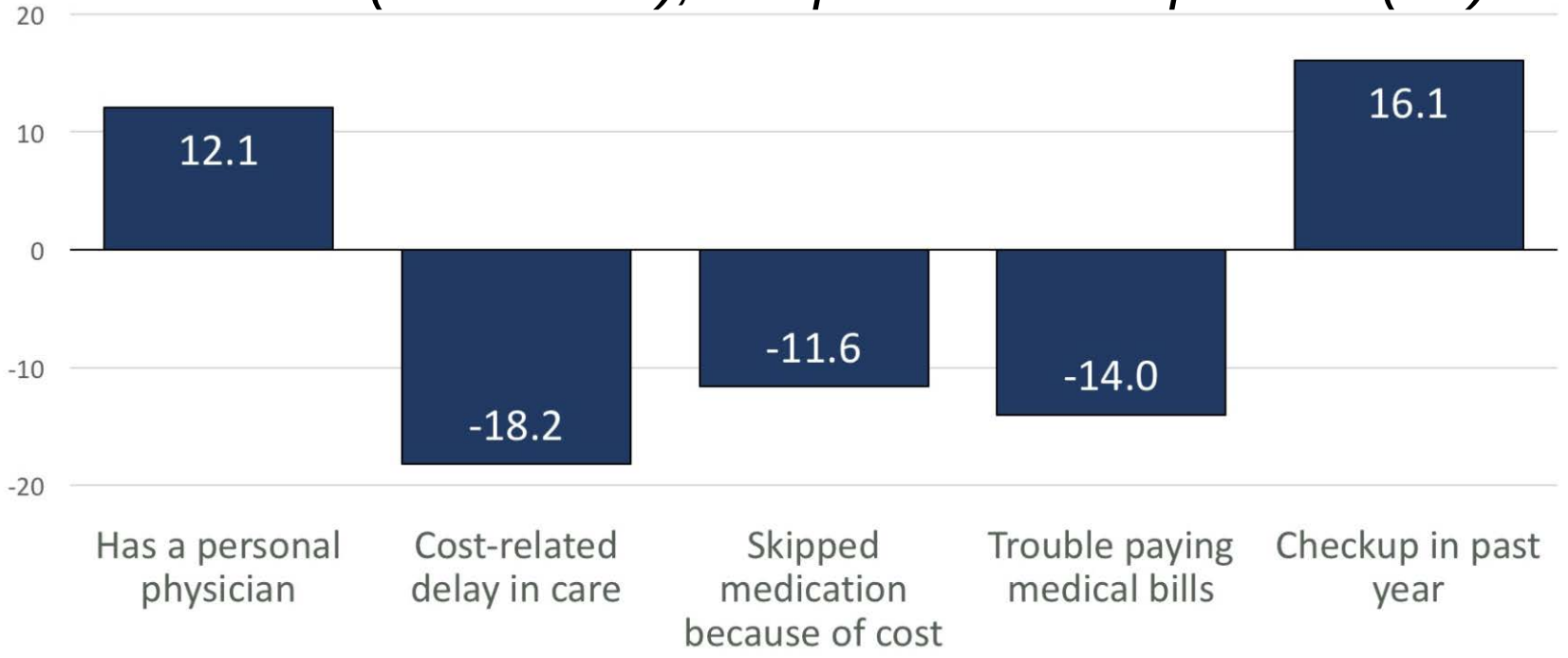
–Seema Verma,
CMS Administrator

"Medicaid is a program that has by and large decreased the ability for folks to gain access to care."

–Tom Price,
Former HHS Secretary

Medicaid Expansion:
Better Access & Affordability

Changes from 2013 to 2015 after Medicaid expansion in two states (KY and AR), compared to no expansion (TX)



Source: *Commonwealth Fund, "In the Literature,"* Adapted from *Sommers et al., JAMA Int Med 2016*

Types of Health Care Use

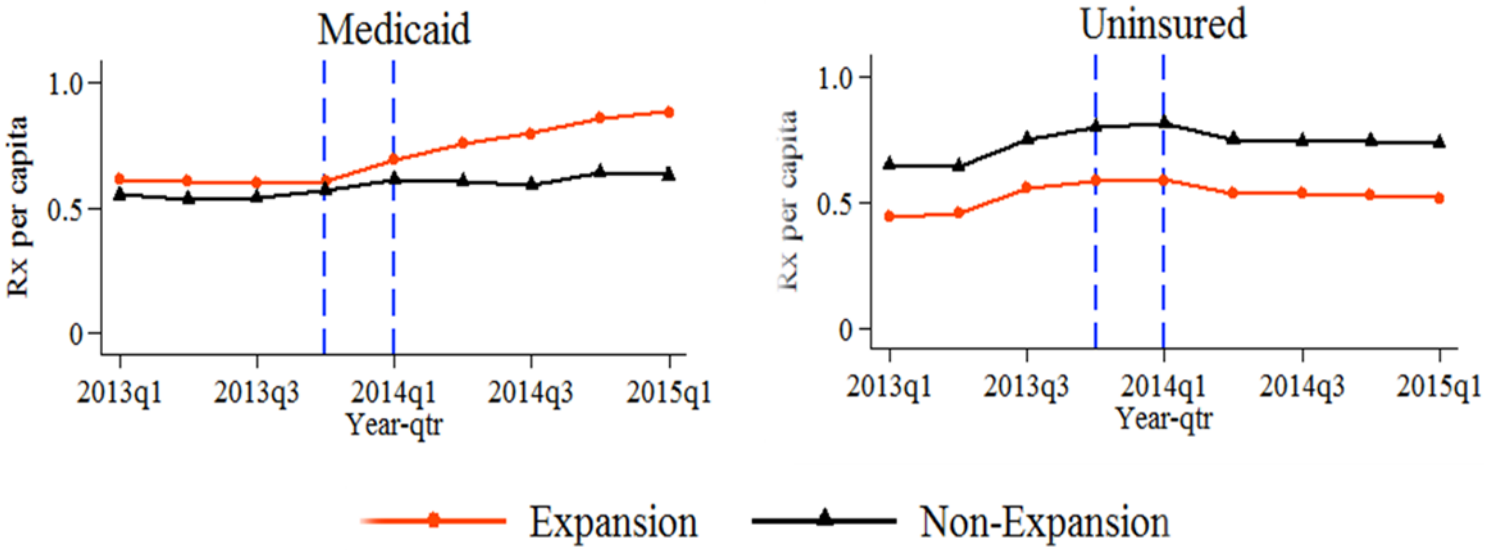
Table 2. Changes in Coverage, Access to Care, Utilization, and Health after the ACA Medicaid Expansion[a]

Outcome	Mean in Expansion States, 2013	Net Change After Expansion (Arkansas and Kentucky vs Texas)[b]			
		2014 Net Change, vs 2013 % (95% CI)	*P* Value	2015 Net Change, vs 2013 % (95% CI)	*P* Value
Any office visits in past year	55.5	2.5 (−3.4 to 8.4)	.41	3.0 (−3.8 to 9.7)	.38
Any ED visits in past year	21.0	−1.9 (−7.6 to 3.8)	.51	−6.0 (−11.7 to 0.3)	.04
No. office visits in past year	2.80	0.54 (−0.33 to 1.40)	.22	0.69 (0.05 to 1.33)	.04
No. ED visits in past year	1.16	−0.12 (−0.45 to 0.21)	.48	−0.09 (−0.45 to 0.27)	.62
Any hospitalization in past year	16.9	−1.5 (−6.8 to 3.7)	.57	2.1 (−3.1 to 7.3)	.43
ED is usual location of care[c]	9.6	−5.2 (−10.5 to 0.1)	.06	−6.1 (−10.1 to 2.2)	.003
Glucose check in past year	43.0	2.3 (−5.2 to 9.8)	.54	6.3 (0.0 to 12.6)	.05
Glucose check among those with diabetes[f]	86.2	4.3 (−7.5 to 16.1)	.47	10.7 (1.2 to 20.2)	.03
Regular care for chronic condition[g]	65.7	11.6 (2.0 to 21.2)	.02	12.0 (3.1 to 21.0)	.008

- *More office-based care, preventive care, and chronic disease management*
- *Less reliance on the Emergency Department*

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016

Prescription Drug Use



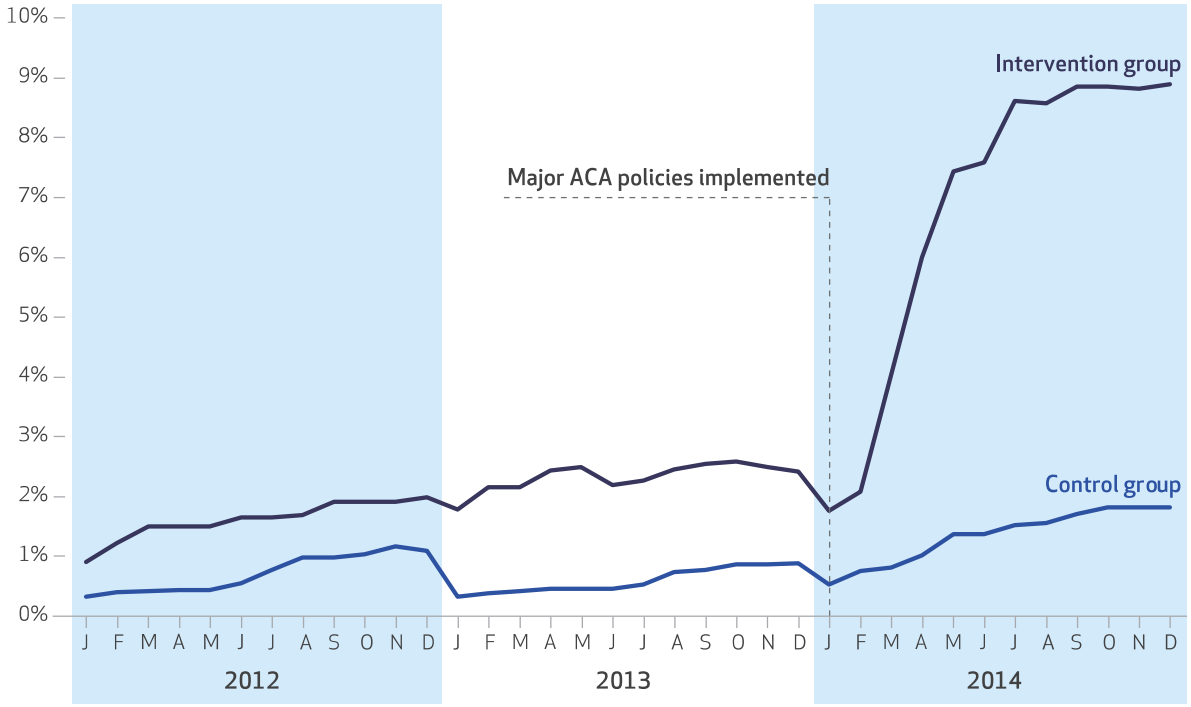
- *Overall Effect:* 19% increase in Medicaid prescription drug utilization by mid-2015
- *Largest Gains* - Diabetes Medications 24%, Birth Control 22%, Cardiovascular Medications 21%

Notes: *"*Rx per capita*" is per non-elderly adult in the state (not just Medicaid beneficiaries).*
Source: *Ghosh, Simon, and Sommers 2017 NBER Working Paper*

What About the Marketplaces?

EXHIBIT 3

Percentages of adults ages 18–63 with family incomes of 138–400 percent of the federal poverty level and nongroup private coverage, 2012–14



- *Insurance gained via non-group private coverage (i.e. Marketplaces)*
- *Led to increased rates of office visits and prescriptions filled*
- *Increased diagnoses of high BP & cholesterol*

Notes: Intervention group – uninsured in Year 1 and income 138-400% poverty line; Control group – stable employer coverage in Year 1 and income 138-400% of poverty line.
Source: Goldman, McCormick, Haas, & Sommers, *Health Affairs 2018*

Care Quality & Health Outcomes

THE WALL STREET JOURNAL.
WSJ.com

OPINION | MARCH 10, 2011

Medicaid Is Worse Than No Coverage at All

New research shows that patients on this government plan fare poorly. So why does the president want to shove one in four Americans into it?

By SCOTT GOTTLIEB

Daily Briefing Blog

Does expanding coverage improve health care?

7:00 PM on May 5, 2014

Dan Diamond, Managing Editor

One of the trickiest questions in health policy seems like it should have an obvious answer:

Does giving people health insurance lead to better outcomes?

"We simply don't know yet," Kate Baicker told me last week.

CATO AT LIBERTY

MAY 1, 2013 5:10PM

Oregon Study Throws a Stop Sign in Front of ObamaCare's Medicaid Expansion

By MICHAEL F. CANNON

Quality and Health Status

Table 2. Changes in Coverage, Access to Care, Utilization, and Health after the ACA Medicaid Expansion[a]

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Regular care for chronic condition[g]	65.7	11.6 (2.0 to 21.2)	.02	12.0 (3.1 to 21.0)	.008
Excellent quality of care	28.1	−2.7 (−10.8 to 5.5)	.52	2.2 (−5.2 to 9.5)	.56
Fair/poor quality of care	19.9	−2.5 (−8.9 to 3.9)	.45	−7.1 (−13.6 to −0.6)	.03
Excellent self-reported health	12.2	2.4 (−2.3 to 7.1)	.32	4.8 (0.3 to 9.3)	.04
Fair/poor self-reported health	39.6	0.9 (−6.7 to 8.4)	.82	−3.2 (−11.1 to 4.7)	.43
Positive depression screen, PHQ2 score ≥2	47.5	2.0 (−5.5 to 9.4)	.60	−6.9 (−14.6 to 0.8)	.08

- *Improved chronic disease management*
- *Improved perceived quality*
- *Improved self-reported health status*

Source: Sommers, Orav, Blendon, & Epstein, *JAMA Internal Medicine*, 2016

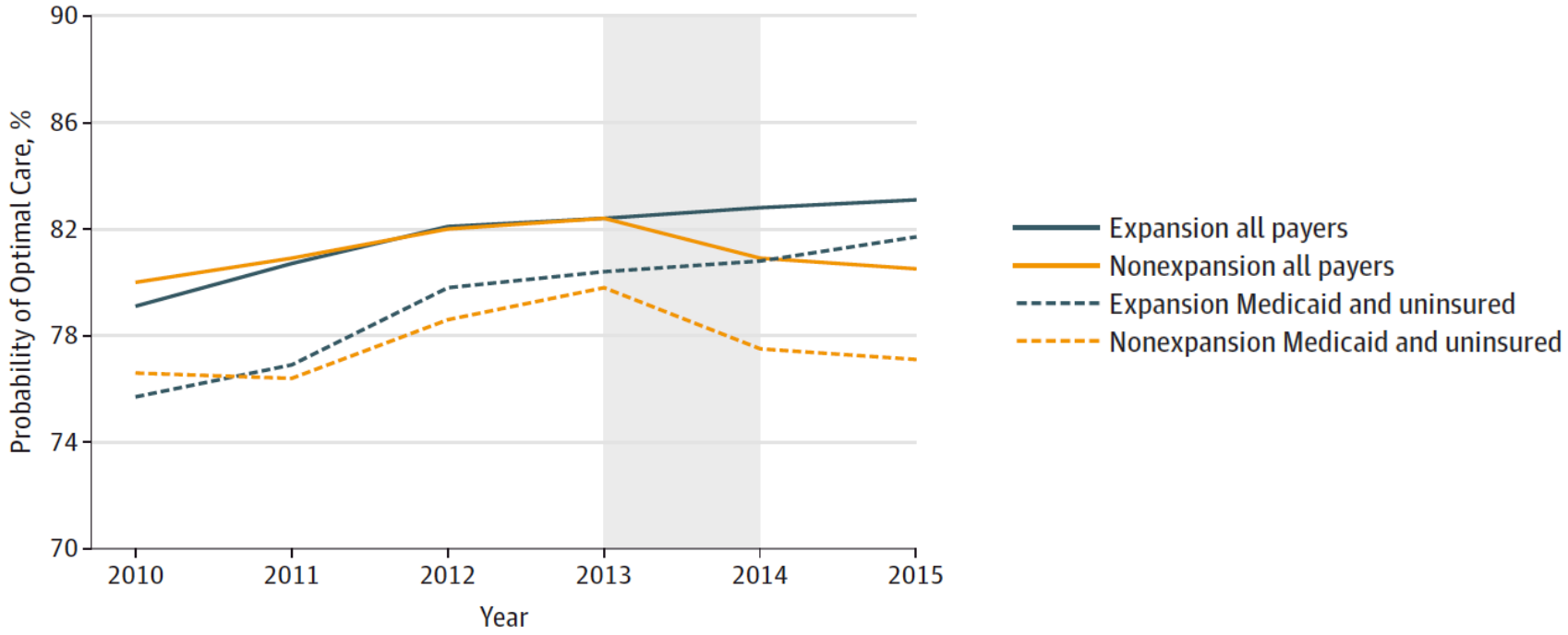
Self-Reported Health

- Consistent finding in our studies of coverage expansions is improved self-reported health
  - State Medicaid expansions in early 2000s
  - Massachusetts health reform in 2006
  - ACA Dependent Coverage Provision in 2010
  - ACA 2014 Marketplace and Medicaid expansions
- Consistent with the Oregon Health Insurance Experiment (RCT of Medicaid coverage)
- Not just "subjective" – prior research shows this is a strong predictor of mortality

Sources: Sommers, Baicker, & Epstein *NEJM* 2012*;* Chua & Sommers*, JAMA* 2014; Wallace & Sommers, *JAMA Peds* 2015; Sommers, Long, & Baicker, *Annals Internal Med* 2014; Sommers, Gunja, Finegold, & Musco, *JAMA* 2015

Surgical Care

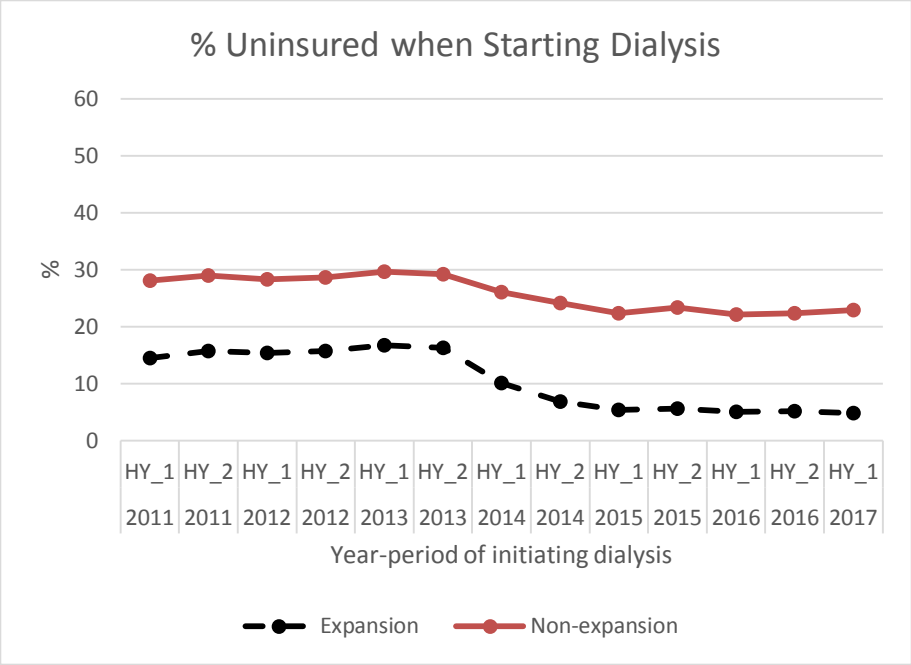
Receipt of optimal care among surgery admissions

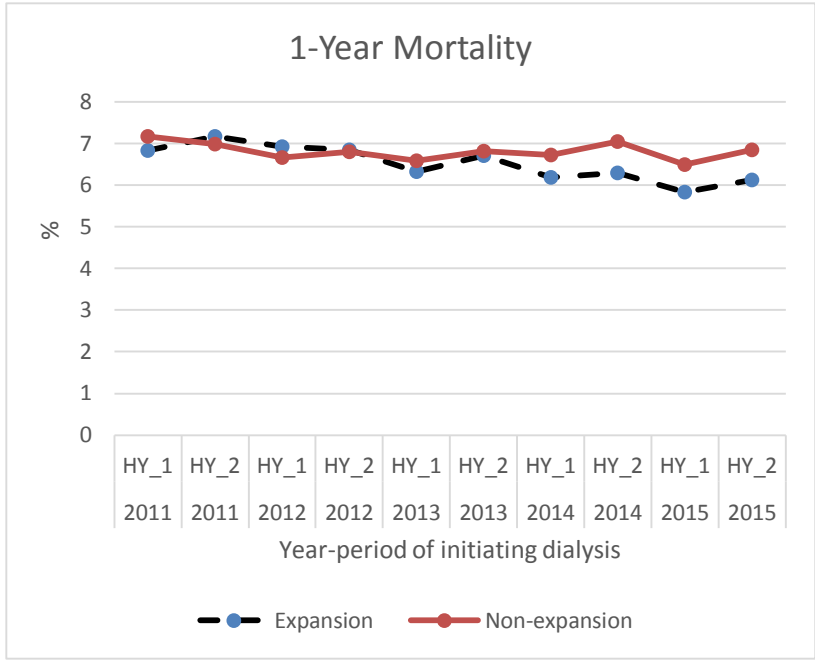


Notes: *Sample contains 281,682 patients admitted to academic medical centers with one of five surgical conditions. "Optimal care" defined as receipt of cholecystectomy when admitted with acute cholecystitis; receipt of minimally-invasive appendectomy or cholecystectomy when undergoing surgery for acute appendicitis or cholecystitis; and avoidance of amputation when admitted with lower extremity peripheral artery disease.*

Source: *Loehrer, Chang, Scott, Hutter, Patel, Lee, & Sommers, JAMA Surgery 2018*

Chronic Illness: ESRD





- *Improved access to nephrology specialty care pre-dialysis*
- *Increased use of fistula / graft for dialysis, which reduces infection and clot risk*
- *1-year mortality: dropped from 6.9 vs. 6.2% (D-in-D = -0.6, p<0.05)*

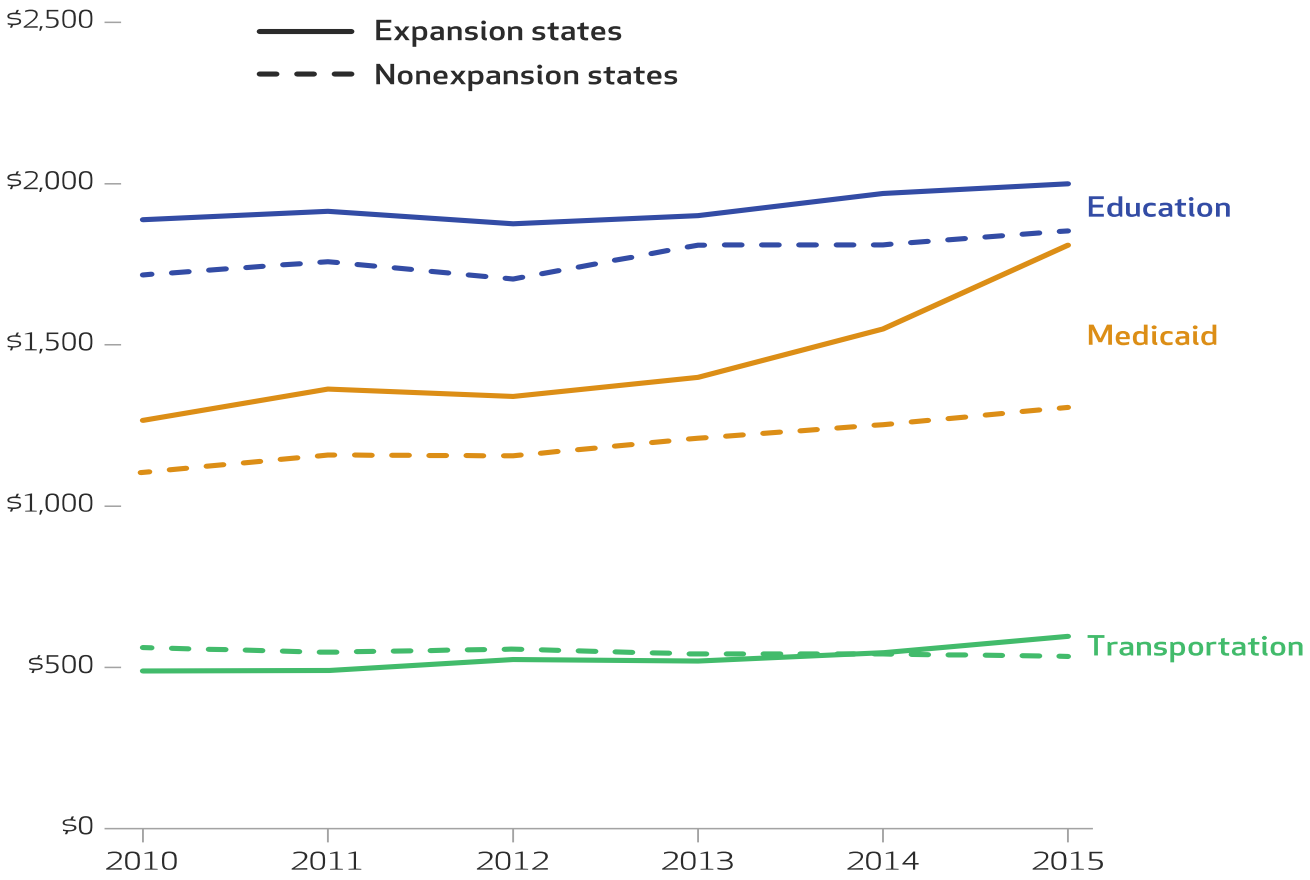
Source: *Shailender, Sommers, Thorsness, Mehrotra, Lee, Gutman, & Trivedi – unpublished (do not cite)*

Medicaid Costs

- ACA expansion covered newly-eligible with 100% federal dollars until 2016, 90% in long-run
- Traditional Federal Medical Assistance Percentage (FMAP) range of 50-83% per state continues for those eligible by pre-ACA criteria
- GOP leaders have proposed changing this to a per capita allotment (and/or block grant) going forward

Expansion Budget Effects

State per capita spending on major spending categories in fiscal years 2010–15, by Medicaid expansion status



Source: Sommers & Gruber, *Health Affairs* 2017

Budget Effects, FY 2010-2015

OUTCOME	MEDICAID EXPANSION EFFECT		% NEWLY-ELIGIBLE EFFECT	
	Percent Change from Expansion	p-value	Change per 1% Newly-Medicaid Eligible	p-value
Total Spending	5.8%	.002	0.32%	.048
Source of Funds				
Federal Funds	12.2%	.006	0.51%	.016
State Funds	2.4%	.24	0.17%	.32
--State General Revenue	2.9%	.35	-0.04%	.81
--Other State Funds	3.1%	.54	0.39%	.28
Category of Spending				
Medicaid	11.7%	<0.001	0.86%	<0.001
K-12 Education	-0.9%	.76	-0.08%	.70
Higher Education	-5.0%	.25	-0.66%	.15
Transportation	8.0%	.062	0.42%	.20
Corrections	-0.4%	.88	-0.17%	.35
Public Assistance	3.6%	.60	-0.21%	.67
Other	10.1%	.057	0.62%	.13

Source: Sommers & Gruber, Health Aff 2017

Trump Era: Legislative Changes

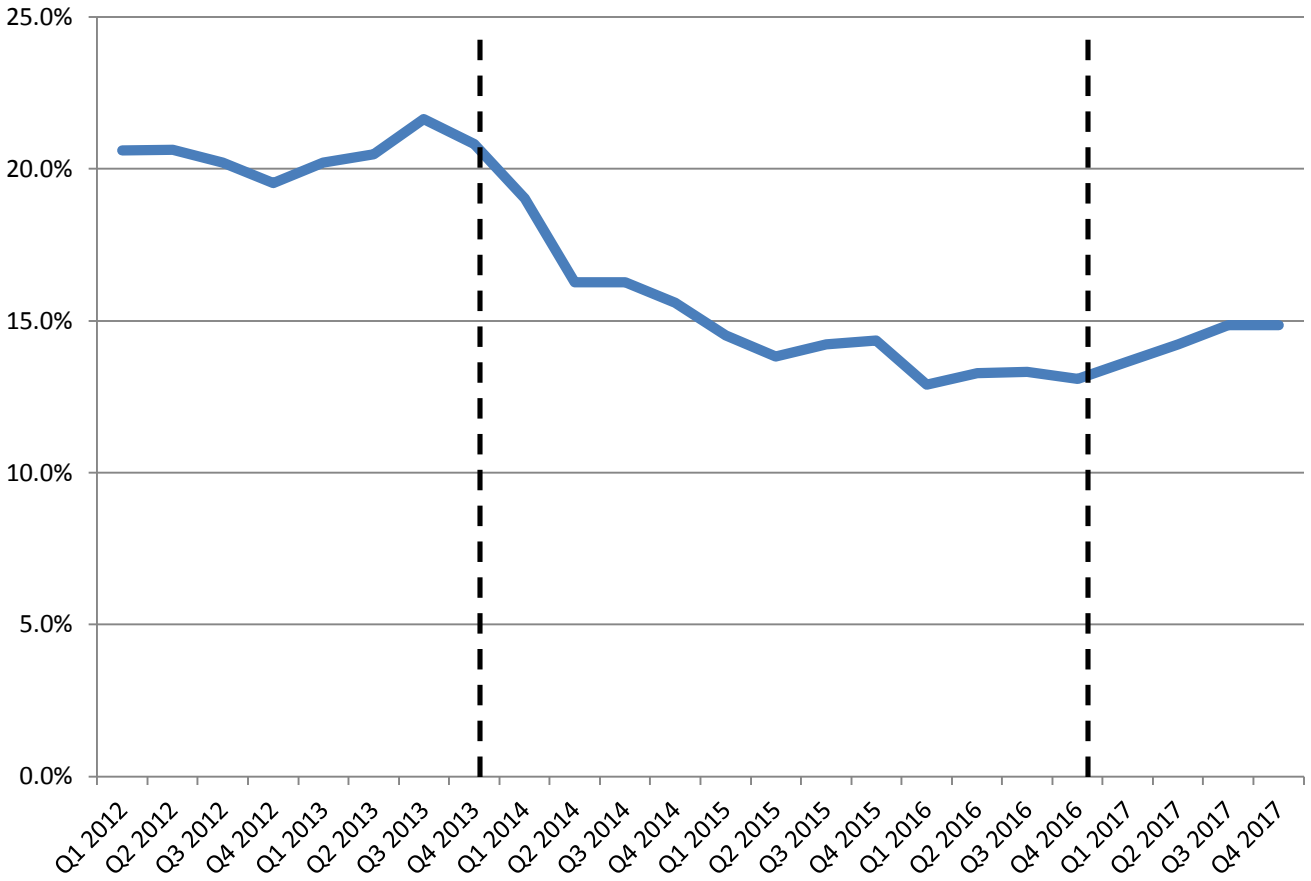
- Multiple efforts to “repeal and replace” the ACA failed during 2017, usually by narrow margins in the Senate
- Tax law passed in December removed individual mandate for 2019
  - Expected to increase premiums in the ACA insurance Marketplaces, and reduce coverage by millions (?)

Trump Era: Changes in ACA Oversight

- Even without a full repeal, the administration has ample discretion:
  - Cutting advertising for Marketplace outreach
  - Shortening open enrollment periods
  - Stopping payments to insurers for cost-sharing reductions for lower-income households
  - Allowing new, less comprehensive “association health plans” to be offered

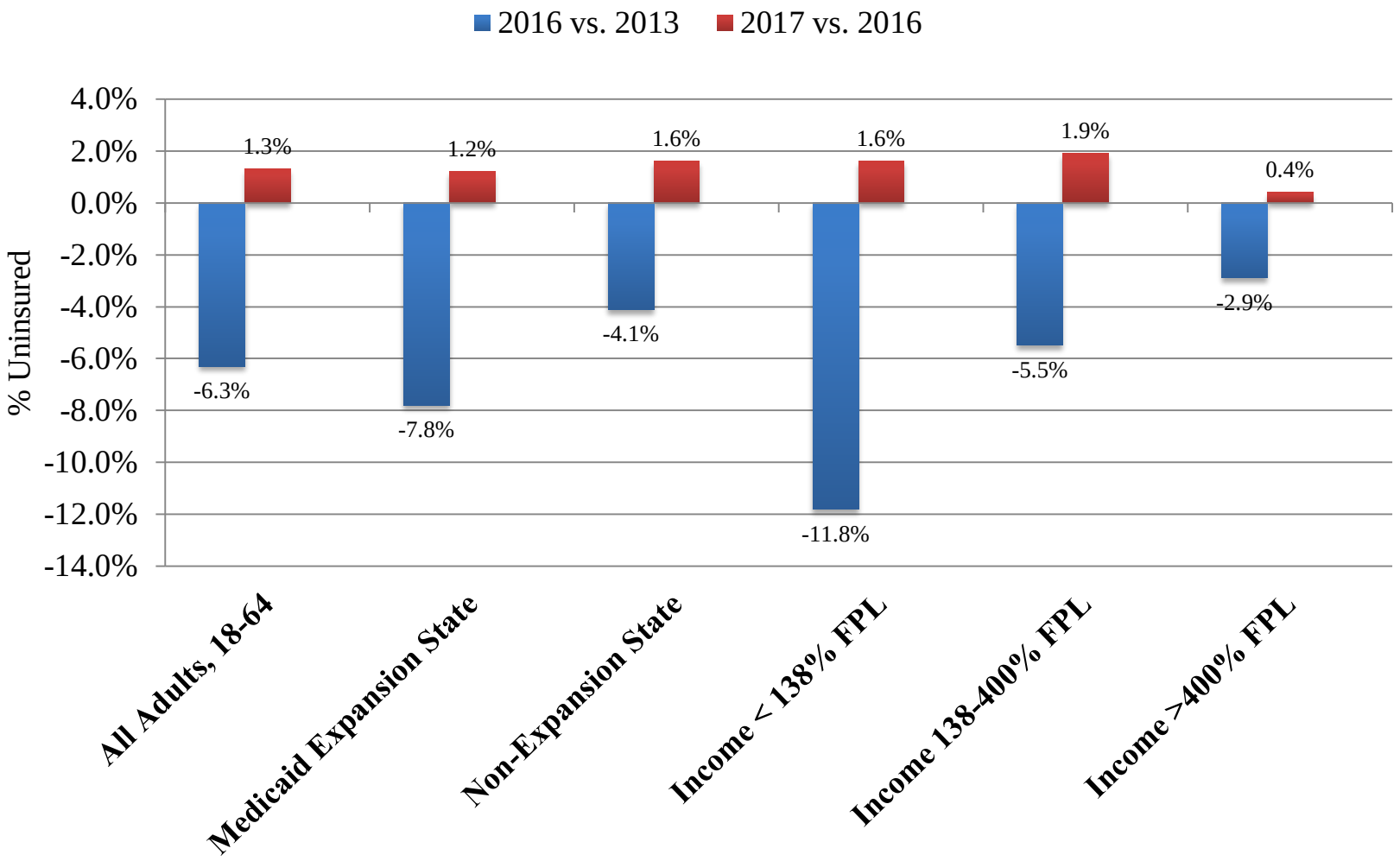
Trump Era: Early Coverage Changes

% Uninsured (19-64)



Source: Sommers, Clark, & Epstein, *NEJM* 2018

Trump Era: Early Coverage Changes



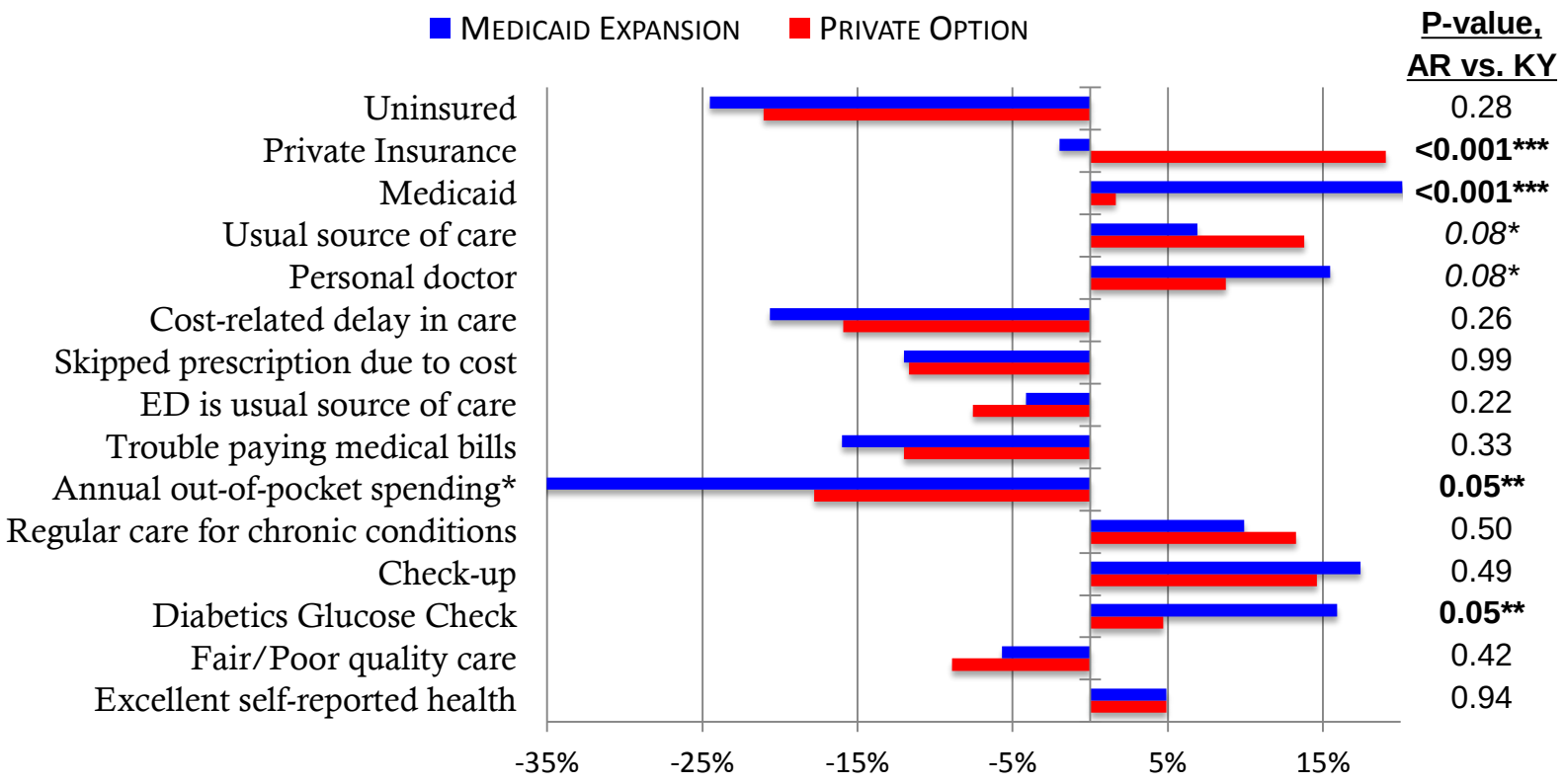
Source: Sommers, Clark, & Epstein, *RWJF Issue Brief,* 2018

Alternative Coverage Expansions

- Via state experimentation and federal waivers, increased interest in alternative expansions
- "Private Option" – use Medicaid dollars to buy private insurance (AR, IA, MA proposal)
- Health Savings Accounts (IN, AR), more cost-sharing (many)
- Healthy Behavior Incentives (MI, IA, IN)
- Work Requirements (AR, KY, IN, NH approved; KS, OH, and others have proposed)

Private Option vs. Medicaid:

Both Beneficial, Few Differences



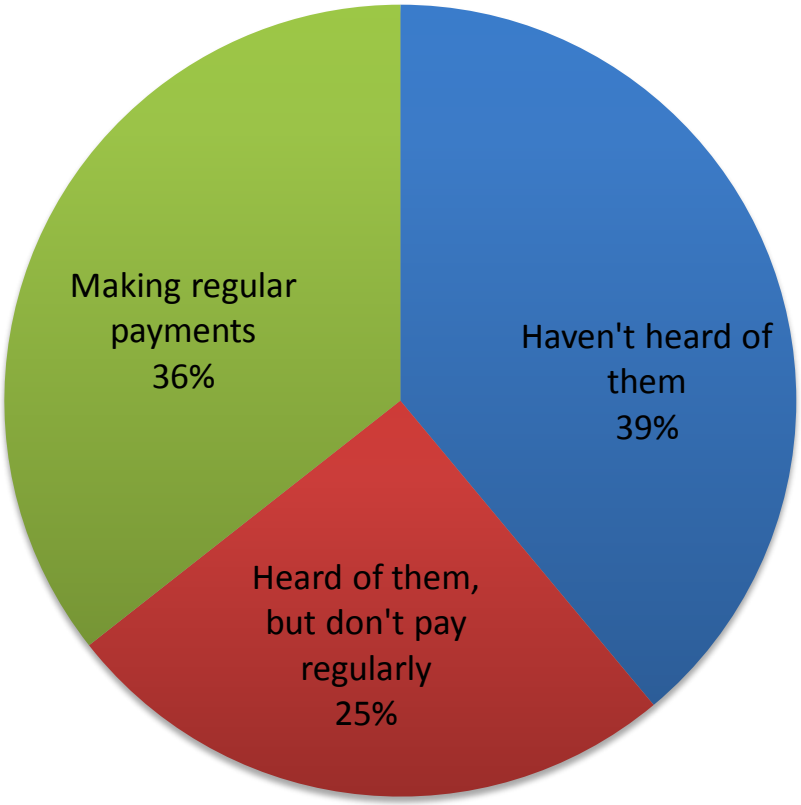
Notes: Bars show difference-in-differences comparison, relative to non-expansion (Texas).
* Outcome is Log(Spending), with estimate reported as percent change. All other estimates are percentage-points.

Source: Sommers, Orav, Blendon, & Epstein, JAMA Internal Medicine, 2016

Health Savings Accounts:

Lots of Confusion, Affordability Problems

Indiana Medicaid: POWER Health Savings Accounts



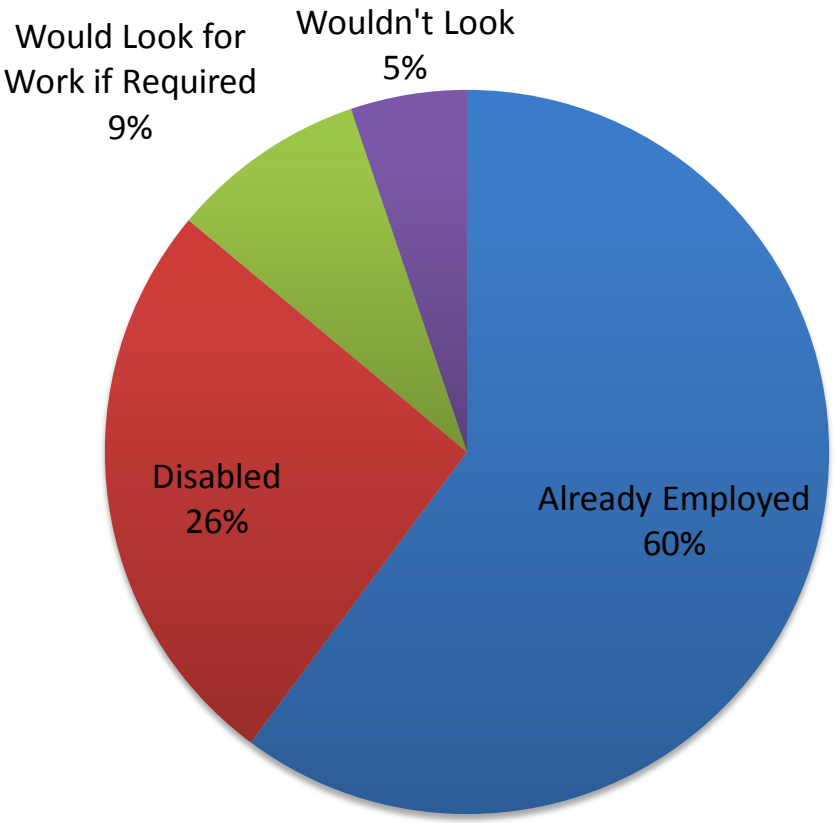
Source: *Sommers, Fry, Blendon, & Epstein – unpublished (do not cite)*

Note: Survey of 300 adults in Indiana Medicaid, ages 19-64, with incomes < 138% of the federal poverty level

Work Requirements:

Small effects on employment – at what cost?

Kansas Medicaid: Potential Effects of Work Requirements



Source: *Sommers, Fry, Blendon, & Epstein – unpublished (do not cite)*

Note: Survey of 1000 adults in Kansas ages 19-64, with incomes < 138% of the federal poverty level

Concluding Thoughts

- The ACA had brought the U.S.'s uninsured rate to an historic low
- Medicaid expansion has improved access to care, quality of care, & some health outcomes – but there's still more room to improve
- Lots of policy uncertainty for ACA and Medicaid going forward, and some recent erosion of ACA coverage gains already evident

Concluding Thoughts

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Health Insurance Coverage and Health — What the Recent Evidence Tells Us

Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H.,
and Katherine Baicker, Ph.D.

Questions & Comments?

Thank you!

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