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The Effect of the Affordable Care Act on the Financial Stability of the Healthcare System

Andrew Emrick
goarmy897@aol.com

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Andrew Emrick

Murray State University

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G. Michael Barton

Abstract

This paper explores published articles that report on results from research conducted about the successes of the Affordable Care Act and its relationship to the financial health of the healthcare industry. While efforts of the ACA to move healthcare towards financial stability have broad sweeping implications across the healthcare industry it is not clear whether the efforts were enough to stem the rising costs of healthcare in the United States. Ellis and Orszag (2007), theorized that the changes under the ACA to further educate patients on treatments would lead to a reduction in healthcare expenditures. Regulatory changes to the insurance marketplaces and acquisition and usage of healthcare insurance have played a prolific role in changing the face of the healthcare industry. Changes in policy, procedure and staffing have already begun to impact the costs of healthcare in America but flaws still exist in the system that are not directly addressed by the ACA. Cutler (2015) states, "The healthcare industry must make efforts to cut costs as the current situation of cost compared to economic growth is unsustainable" (p. 337). This paper examines the steps already taken by the ACA to achieve balance in healthcare expenditures and to prevent healthcare costs from further spiraling out of control.

Keywords: Affordable Care Act

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INTRODUCTION

The Affordable Care Act was a vision of former President Barack Obama of a better system of healthcare delivery and execution. The campaign promises of sweeping healthcare reform were made manifest in what is the Patient Protection and Affordable Care Act. The shortened title of Affordable Care Act is also interchangeable with the colloquial reference often referred to in American media; Obamacare. As stated by Affordable Care Act history (n.d.), The Patient Protection and Affordable Care Act was signed into law by President Obama in March 2010. Its major provisions went into effect Jan. 1, 2014, although significant changes went into effect before that date and will continue in years to come. While the ACA has had sweeping effects on the healthcare industry as a whole, it is widely misunderstood by the American populous. As Nyhan (2017) shows, "In the survey, 35 percent of respondents said either they thought Obamacare and the Affordable Care Act were different policies (17 percent) or didn't know if they were the same or different (18 percent). This confusion was more pronounced among people 18 to 29 and those who earn less than $50,000." So, while the Affordable Care Act remains steeped in controversy, seven years after being signed into law, there is still room to garner understanding and insight into what the Act stands to achieve and how it effects the financial stability of the healthcare system overall.

CONSTITUTIONALITY OF THE ACA

The first major hurdle faced by the Affordable Care Act was opposition of the bill on constitutionality. The initial claim of unconstitutionality was in reference to a subsection of the Affordable Care Act which mandates the American people purchase healthcare coverage under the newly formed state and federal healthcare exchanges. As Elias (2013) states, "In June 2012,

the Supreme Court declared the ACA is unconstitutional, since it violated the Commerce Clause, which stipulates the government cannot compel individuals to engage in commerce — that is, to purchase goods and services." While forcing Americans to purchase any services or product from federal mandate is clearly unconstitutional the Obama administration circumvented this issue by enforcing the purchase of healthcare coverage insurance through a tax penalty.

In addition to, the possible unconstitutionality of the Affordable Care Act in regards to forcing Americans to purchase healthcare coverage insurance, the manner in which the Obama administration circumvented the issue by imposing a tax was also not legally sound. As Elias (2013) states, "According to article I, section 7, clause 1 of the U.S. Constitution, tax measures need to originate in the House due to the Origination Clause. The thinking here is that House members represent their constituents more closely than Senators and the power of the purse should reside closest to the people and their direct representatives." This clause of the United States constitution would therefore disallow the Affordable Care Act legislation to enact a tax from the executive branch of the government. While this at face value would make it appear as though the Affordable Care Act is genuinely unconstitutional history would prove otherwise. As Liptak (2012) states, "The Supreme Court on Thursday upheld President Obama's health care overhaul law, saying its requirement that most Americans obtain insurance or pay a penalty was authorized by Congress's power to levy taxes. The vote was 5 to 4, with Chief Justice John G. Roberts Jr. joining the court's four more liberal members" (p. 1). This decision by the Supreme Court was a major victory for the Affordable Care Act and the final remaining decision on the overall constitutionality of the legislation.

IMPLEMENTATION OF THE ACA

The implementation of the Affordable Care Act began almost immediately after being signed into law on March 23rd, 2010. By the end of July 2010, the Affordable Care Act had initiated small business tax credits as stated by Services (2016), "access to the federal high-risk pool for the uninsured with pre-existing conditions, reinsurance for retiree health benefit plans and pre-existing condition insurance plans." Following the 90-day implementation plans the Affordable Care Act set forth mandatory goals for the first 180 days of the bill. Services (2016) states, that the Affordable Care Act close the coverage gap for Medicare Part D, create a health insurance consumer information platform and ensure no pre-existing conditions coverage exclusions for children. Further changes implemented under the Affordable Care Act were broken down by year which the bill required these actions to be completed. The History and Timeline of the Affordable Care Act shows the following changes that were enacted by 2011:

- Patient protections for all new plans: This provision protects patients' choice of doctors by allowing plan members to pick any participating primary care provider, prohibiting insurers from requiring prior authorization before a woman sees an obstetrician/gynecologist (ob/gyn), and ensuring access to emergency care.
- Extension of dependent coverage for young adults: Young adults can stay on their parents' insurance until age 26, even if they are not full-time students. This extension applies to all new plans.
- "First-dollar" prevention benefits: All new health insurance policies must cover preventive care and pay a portion of all preventive care visits.

- No lifetime limits on coverage: This eliminates any maximum dollar amount that a health insurance company agrees to pay on behalf of a member for covered services during the course of his or her lifetime.
- Restricted annual limits on coverage: This eliminates any limits or maximum payouts from the health insurance company.
- Prohibits rescission: The ACA prohibits rescission when a claim is filed, except in the case of fraud or misrepresentation by the consumer.
- Appeals process: When a consumer has a problem with his or her coverage, the insurance company must provide a process for customers to make an appeal. (Services, 2016).

Additionally, the History and Timeline of the Affordable Care Act presents the changes enacted by the Affordable Care Act as of 2014:

- October 1, 2013: Health insurance exchanges scheduled to open for 2014 enrollment: Begin writing policies that go into effect January 1 of the coming year.
- January 2014: Federal subsidies for health insurance coverage: People buying insurance on their own get subsidies to help them pay their monthly insurance premiums. Premiums are allocated on a sliding scale, as determined by income. Any individual earning over 400% of the poverty level ($43,320 in 2009) doesn't qualify for subsidies.
- January 2014: Small business tax credits: When health insurance exchanges are operational, tax credits are up to 50% of premiums.
- January 2014: No restrictions on pre-existing conditions: Insurance companies are required to provide health insurance to any adult aged 19 to 64 who applies for coverage.

- January 2014: Requirement to buy health insurance: To prevent people from waiting until they get sick to buy health insurance, the ACA requires all Americans to buy health insurance or pay a fine. The fine starts at $95 for an individual in 2014 and goes up each year until 2016, when the fine is the largest of the following two:$695 or 2.5% of a person's annual income.
- January 2014: High-Risk Insurance Pools Expire: Pre-Existing Condition Insurance Plans (PCIPs), established in 2010 are scheduled to expire on January 1, 2014 once all of the major ACA reforms were in effect. (Services 2016).

The Affordable Care Act is quickly approaching the timetable of complete implementation. The bill sought to make smaller changes gradually over a 10 year period so as not to overburden the healthcare industry. The following changes as stated by the History and Timeline of the Affordable Care Act show the final stages which are still awaiting implementation:

- January 2017: "Grandmothered" health insurance plans become illegal. Grandmothered health insurance plans are individual health insurance plans purchased after the Affordable Care Act was signed into law (March of 2010), but before they became illegal, which was January 1, 2014. In some states, the deadline for these plans to be phased out was extended until 2017.
- January 2018: All existing health insurance plans must cover preventive care and checkups without copayments.
- January 2020: The Medicare Part D coverage gap ("donut hole") is phased out. (Services 2016).

EXPANSION OF SOCIAL PROGRAMS

Understanding the staggered approach of implementation of the Affordable Care Act gives perspective into how the bill is effecting the healthcare industry. With a complete picture of how the bill was intended to be received and implemented we can look into how these processes have augmented and changed the face of the healthcare industry. Only by understanding the changes and new regulations can we truly see how these actions have affected the financial stability of healthcare organizations and the industry as a whole.

A major provision of the Affordable Care Act was the expansion of social programs, primarily Medicaid, in an effort to lower the number of uninsured individuals in the population. The act of expanding Medicaid was a monumental undertaking both from a logistical and financial standpoint. Under the Affordable Care Act states had the option if they were going to expand Medicaid coverage in their states. As Holahan (2012) states, "State decisions about whether to implement the Medicaid expansion will be shaped in part by the costs to states. A key factor in assessing these costs is the incremental state cost and new federal funding tied to implementing the ACA Medicaid expansion (p. 5). To consider how individual states decided on their participation we must look at state spending versus federal aid to Medicaid expansion and how it affected healthcare and state finances.

Cost to states for expansion of Medicaid

The expansion of Medicaid by the states was partially financed by the state and further funded by federal subsidy. Initial figures estimated that "The Medicaid expansion and other provisions of the ACA would lead state Medicaid spending to increase by $76 billion over 2013-2022 (an increase of less than 3%), while federal Medicaid spending would increase by $952

billion (a 26% increase)" (Holahan 2012). This figure was hypothesized initially if all states in the union participated in the expansion of Medicaid legislated in the Affordable Care Act. Under the provisions of the Affordable Care Act, Medicaid expansion was partially funded by the states while the federal government absorbed the brunt of the financial burden. (See Appendix A)

Another fact to consider with the expansion of Medicaid is increased cost to states relative to total overall Medicaid spending. While the expansion of a social program which is already taxing may appear at first to be a contentious issue the Affordable Care Act alleviated some of these worries in the manner in which it was designed. As Holahan (2012) states, "State decisions about whether to implement the Medicaid expansion will be shaped in part by the costs to states." The propensity of states to expand Medicaid of their own volition is limited by state resources. All increases in state budgets must be considered heavily in states that are not especially profitable in their tax revenue. With this in mind the Affordable Care Act set to alleviate these issues: "If all states implemented the expansion, this incremental state cost would be $8 billion, increasing state Medicaid spending by 0.3%, but the increase in federal spending would be $800 billion, or 21%" (Holahan 2012). This expansive government subsidy to the states was to incentivize more states to expand their Medicaid programs without fear of bankrupting their state governments. While this plan was effective in garnering more than 50% of states to participate in state expansion of Medicaid functions it was not enough to convince all states to do so.

After identifying the avenues for Medicaid expansion, it is obvious why the vast majority of states decided to expand Medicaid services under the Affordable Care Act. Although state spending did increase initially the overall cost to states to expand Medicaid programs was all together underwhelming. Interestingly enough, Holahan (2012) states:

> "If all states adopted the Medicaid expansion, total uncompensated care would decline by approximately $183 billion from 2013-2022 compared to the ACA if no states expanded Medicaid. States and localities finance about 30% of uncompensated care costs for the uninsured, and we assume that states and localities will achieve only 33% of the savings on their share of this funding. Under that conservative assumption, state and local spending on uncompensated care would decline by $18 billion—in effect, 10% of the expansion's total reduction in uncompensated care" (p. 6).

This direct savings in uncompensated care costs would further alleviate the inhibitive costs of implementing the Medicaid expansions on a statewide level. With the costs of Medicaid expansion essentially alleviated from state budgets it leaves a question of why only approximately half of the states decided to participate in the optional statewide Medicaid expansions included in the Affordable Care Act.

Additionally, state expansion of Medicaid is not found to be exclusive to one political party. There is an equal representation of states which expanded their Medicaid programs under the Affordable Care Act as demonstrated in appendix B. This trend in Medicaid expansion under the Affordable Care Act shows that the monetary benefits as well as the benefits to indigent communities was realized by both Republicans and Democrats in the United States at a relatively equal rate.

Newly insured under Medicaid expansion

The first area in which healthcare coverage has grown is directly related to the expansion of Medicaid programs. While not all states decided to participate in the expansion of Medicaid programs those who did saw a sweeping increase in the number of indigent individuals receiving healthcare coverage. According to Blumenthal, Abrams and Nuzum (2015),

> "A total of 28 states and the District of Columbia have taken advantage of this opportunity, but even in those that have not done so, Medicaid enrollments have grown as some persons seeking insurance through ACA insurance marketplaces have discovered they are, in fact, eligible for Medicaid under pre-ACA rules. A total of 10.8 million additional Americans have enrolled in Medicaid since the enactment of the ACA."

While the aim of the Affordable Care Act to insure every American was not entirely successful, the strides of the bill cannot be denied. As can be seen in appendix C the proposed rate of uninsured Americans will continue to drop steeply if the Affordable Care Act remains in place. With a considerable uptick in Medicaid coverage more indigent Americans are now covered with a health insurance plan. This increase in coverage to indigent individuals has a direct link to hospital profitability.

As more individuals are insured under the expansion of Medicaid hospitals now have a source to bill for services whereas before the emergency services provided often times led to uncompensated care, also referred to as, bad debts. While overall the states may have to spend more money on a very minute scale to expand Medicaid functions in the states the effect of doing so would rapidly decrease bad debts with local hospitals due to extended coverage under Medicaid. As Dranove, Garthwaite, & Ody (2016) state,

> "We estimate that in states that expanded Medicaid under the ACA, uncompensated care costs decreased from 4.1 percentage points to 3.1 percentage points of operating costs. The reductions in Medicaid expansion states were larger at hospitals that had higher pre-ACA uncompensated care burdens and in markets where we predicted larger gains in coverage through expanded eligibility for Medicaid."

Although there is little research in the area of linking indigent populations with Medicaid expansion versus bad debts associated with medical organizations the cognitive leap is easy to make. The rise of coverage for indigent populations has caused a decrease in the amount of bad debts suffered by individual healthcare organizations and as such the profitability of these corporations has risen. Albeit the effects of the Affordable Care Act and expansion of social programs are more pronounced in areas with populations most effected by the increases in Medicaid coverage. Additionally, Dranove, Garthwaite, & Ody (2016) state, "Our estimates suggest that uncompensated care costs would have decreased from 5.7 percentage points to 4.0 percentage points of operating costs in nonexpansion states if they had expanded Medicaid." So while the states that chose not to expand Medicaid under the Affordable Care Act are at face value saving money for their state governments they are in effect creating financial burden on the healthcare industries of their respective states. Lack of relief in uncompensated or bad debts by hospitals has a corollary effect on overall healthcare industry financial health which in turn has a greater effect on organizations to employ individuals. Dranove, Garthwaite, & Ody (2016) state, "Thus, while the ACA decreased the variation in uncompensated care costs across hospitals within Medicaid expansion states, the difference between expansion and nonexpansion states increased substantially." States which chose not to expand Medicaid had an inverse effect on the

healthcare industry's ability to remedy uncompensated care and ultimately undermine the financial stability of the healthcare organizations within their states.

Extending coverage to adult children

In addition to the expansion of Medicaid, a provision of the Affordable Care Act was the ability for children aged 26 and under to gain coverage under their parent's insurance plans. This was possible before for dependent children to be covered under a parent's health insurance plan up until age 18 or till age 22 with an extension if the dependent child was a full-time college student. Under the new provisions of the Affordable Care Act children up to the age of 26 would be allowed to be covered under their parent's health insurance coverage. According to Blumenthal, Abrams and Nuzum (2015),

> "nearly 3 million previously uninsured young Americans have gained coverage under their parents' policies because the ACA requires all private insurers and employers that offer dependent coverage to cover children until they are 26 years of age, regardless of whether they are dependent for tax purposes."

This provision afforded adult children the ability to be covered under a decent health insurance plan while seeking employment in a post collegiate world. This subsection of the Affordable Care Act is a major proponent in lowering the rate of uninsured especially in regards to the young adult demographic. As Kenney, Zuckerman, Dubay, Huntress, Lynch, Haley & Anderson (2012) state,

> "Young adults have higher uninsured rates relative to other adults, thus constraining their access to acute and preventive care, including mental health care, and contributing to financial hardships associated with meeting health care needs during a critical time of

> life. According to a Commonwealth Fund study, of the nearly two in five young adults ages 19-29 who were without health insurance for some or all of 2011, 60 percent said they did not receive needed care because of costs and half reported problems paying medical Timely Analysis of Immediate Health Policy Issues 5 bills or said they were paying off medical debt "(p. 4)

Once again the theme of extending needed coverage has a profound effect on lowering uncompensated care at healthcare organizational levels. In addition to lowering bad debts from acute medical services the expansion of coverage to young adults allows for easier access to primary care which has been found to be the most cost effective method in treating ailments. If these young individuals are allowed access to primary care at an affordable rate they much less likely to allow their medical conditions worsen to the point of acute specialized care. Therefore the allowance of nondependent young adults to receive healthcare coverage through the Affordable Care Act's provision which allows coverage under their parent's healthcare plans has a direct effect on the financial wellbeing of the healthcare industry.

Changes to hospital regulations

Along with the Affordable Care Act came major changes to hospital regulations. Hospitals are now having Medicare reimbursements tied to readmission rates and other factors such as rate of hospital acquired conditions and patient satisfaction. While this may seem as though it is a step in the correct direction one must look at the ramifications of such wide sweeping regulatory changes. What effects are these changes having on healthcare organizations across the nation and are the benefits worth the sacrifices made by the healthcare industry.

Change to Medicare reimbursements

The first regulatory change we will focus on is the section of the Affordable Care Act that changed the manner in which hospitals are reimbursed for care for Medicare patients especially if the patients are readmitted within 30 days of discharge from the healthcare organization. As Serrie (2012) states,

> "Medicare will reduce reimbursements to hospitals with high 30-day readmission rates -- which refers to patients who return within a month -- by as much as 1 percent. The maximum penalty increases to 2 percent the following year and 3 percent in 2014."

While this change would seem beneficial in regards to stopping hospitals from discharging patients on the unethical grounds of seeking more reimbursements from Medicare upon readmission it also poses logistical problems. The change in reimbursement towards readmission of Medicare patients has so far been successful in its original intention. As Blumenthal, Abrams and Nuzum (2015) state, "Since the initiation of the program, 30-day readmission rates nationally have declined from more than 19.0% to less than 18.0%, equivalent to approximately 150,000 fewer readmissions annually among Medicare beneficiaries." Overall this particular subsection and regulatory change in the Affordable Care Act has been successful in lowering the overall percentage of Medicare readmissions. (See appendix D) While cutting unnecessary costs to the Medicare program is absolutely needed the implications of this regulatory change are more far sweeping.

While the regulatory change to Medicare may prove to lower the overall costs associated with Medicare, it may not actually be beneficial to patients. Serrie (2012) finds that, "'Among patients with heart failure, hospitals that have higher readmission rates actually have lower

mortality rates,' said Sunil Kripalani, MD, a professor with Vanderbilt University Medical Center who studies hospital readmissions." Under the stipulations of the Affordable Care Act if patients are in need of healthcare within 30 days of their discharge then the hospitals must pay for the services provided upon readmission. If patients are discharged with the intention of not being readmitted to the hospital it may provide an environment that incentivizes cost cutting over patient safety. This practice sets a very dangerous precedent with no discernable winning side for either patients nor healthcare organizations. If organizations provide the best care possible but the patient has ongoing medical issues which seek medical attention, then the hospital is penalized for readmitting the patient. Likewise, if hospitals condition their patients to not seek care due to services provided no longer being financed through Medicare it could lead to patients not seeking necessary medical attention at vital stages where intervention is paramount.

Tying reimbursement to patient satisfaction

While all healthcare organizations attempt to satiate their patient's needs, patient satisfaction and the focus on patient perception of the care they received is quickly coming to the forefront. Under the Affordable Care Act Medicare patients and the reimbursement for services provided are now being tied to patient satisfaction surveys. As Geiger (2012) states,

> "High patient satisfaction ratings have become an urgent but uncertain goal for hospitals in response to Medicare plans, starting this October, to tie a small percentage of reimbursement to "value-based purchasing" bonuses. These bonuses will be determined by comparing hospitals both on their adherence to clinical performance guidelines (70% of weighted score) and on patients' perception of the quality of care (30%)—based on postdischarge survey questions

> on such aspects of care as pain control, cleanliness of rooms, and whether clinicians treated patients with respect" (p. 11).

Although patient satisfaction in any industry is paramount directly tying Medicare reimbursements to patient satisfaction surveys is a dangerous game for the federal government to be meddling in. Not all areas are similar geographically, not only in services but also in patient attitudes and propensities to complain about perceived lack of services or respect. Geiger (2012) states, "Research suggests that high acuity hospitals tend to have lower patient satisfaction scores, patients in some U.S. regions may be less likely to complain, and certain hospitals with superior scores in clinical measures and outcomes suffer from bad patient reviews" (p. 11). This function of the Affordable Care Act's regulatory change to Medicare reimbursement effectively takes focus away from clinical services to appease the public. Services rendered are often a subjective topic that varies from patient to patient and entirely upon their mood at the moment they file the post-discharge survey. This regulatory effect also stands to undermine the stewardship and compassion of healthcare organizations across the board. As Geiger (2012) so eloquently states, "While mandating and measuring compassion doesn't necessarily poison it, doing so misses the heart of nursing. Compassion, empathy, and beneficence are basic virtues from which my nursing care emanates, and I control their exercise" (p. 11). Not only does this regulation create an environment for falsehood in compassion it actively engages healthcare employees to subvert their efforts to appease patients or else their hospital may suffer financial ramifications.

Pain management tied to reimbursement

Pain management is a subsection of the patient survey which as discussed earlier is now directly tied to Medicare reimbursements. A Time article explains that;

> "As part of an Obama-care initiative meant to reward quality care, the Centers for Medicare and Medicaid Services (CMS) is allocating some $1.5 billion in Medicare payments to hospitals based on criteria that include patient--satisfaction surveys. Among the questions: 'During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?' And: 'How often was your pain well controlled?'" ("How Obamacare Is Fueling America's Opioid Epidemic," n.d.)

Once again what may seem as a positive gesture to refocus healthcare organizations on patient wellbeing and satisfaction may have a negative effect on society in general as well as hurting the financial stability of healthcare organizations. This is yet another dangerous precedent being set by the Affordable Care Act in forcing physicians to prescribe pain medication for fear of losing their organization reimbursements. The aforementioned Time article goes on to explain; "In a 2014 survey published in Patient Preference and Adherence, over 48% of doctors reported prescribing inappropriate narcotic pain medication because of patient--satisfaction questions. One doctor wrote that drug seekers 'are well aware of the patient satisfaction scores and how they can use these threats and complaints to obtain narcotics' ("How Obamacare Is Fueling America's Opioid Epidemic," n.d.). By tying pain relief into reimbursement, the federal government through the Affordable Care Act have essentially made a moral quagmire for healthcare industries to wade through. Should the healthcare organizations prescribe pain medication in a fashion that is conducive to patients needs or do they sacrifice their reimbursements to alleviate drug dependence or drug seeking behavior. If a healthcare

organization chooses to err on the side of morality, then patient satisfaction surveys may lower. Although to some larger healthcare organizations the lower reimbursements due to poor patient satisfaction surveys may not be as drastic, to smaller or more rural healthcare organizations this decision of morality may be a deathblow.

Focus on wellness

In addition to wide sweeping changes to reimbursements for Medicare and Medicaid the Affordable Care Act is also attempting to change the manner in which healthcare is delivered. Typically, in the past the healthcare industry has attempted to treat disease and disease processes and have overly neglected keeping individuals healthy before being seen by a healthcare provider. The belief of the Obama administration and the ideas expanded upon in the Affordable Care Act is that with a shift in focus from treating disease as it presents itself the healthcare industry should spend more resources on maintaining wellness in the population before disease becomes a reality.

> "A study published in the September 2010 issue of Health Affairs found that increasing the use of 20 proven clinical preventive services from current levels to 90 percent in 2006 would result in total savings of $3.7 billion, or 0.2 percent of U.S. personal health care spending—while averting the loss of more than two million life-years annually. Among the clinical preventive services were smoking cessation advice and assistance, alcohol screening and brief counseling, obesity screening, and childhood immunizations" ("Focus on prevention and wellness to decrease health care costs", 2017).

While this change in policy and ensuing paradigm shift should technically be extremely beneficial in both reducing overall healthcare costs and increasing population health it is a

monumental task in changing the thought process of all Americans. While technological advancements press medicine forward and make great strides to eliminate disease from the modern world it is an extremely costly venture. When focus is shifted further towards wellness then the problem is effectively alleviated and at a much lower price point by comparison. Ultimately for the wellness imitative to find success is the willingness of the population to change their lifestyles and educated themselves on practices of wellness.

Effects of regulation change on hospitals

The decisions on regulation change within the Affordable Care Act have already begun to create expansive changes within the healthcare industry. As a result of changes to reimbursement additional financial burden has been placed on the healthcare industry. While healthcare facilities have a profound ability to impact infection rates, readmissions, and patient satisfaction there is always a degree of inability to control these new criteria for payment. If patients are noncompliant with their medications or post discharge treatments for instance then they may need readmission to the hospital in which case the hospital is faulted and is subsequently punished financially. Additionally, a patient with a disposition to negatively affect the healthcare facility they received care from can write poor reviews upon discharge which ultimately will effect the reimbursements of the organization in question. With so much subjectivity being introduced into the healthcare industry both the organization and its employees must cater to the fickle wants and needs of the uneducated masses which even if satiated may still give poor scores. Shifting the focus of healthcare workers from providing the most excellent healthcare achievable to coddling the feelings or patients is a dangerous endeavor and can lead to interference with the ethical responsibility of healthcare workers towards the best interests of their patient base. While the original intent of the regulatory were to help the patient receive

more complete and caring treatment it may cause grievous damage to healthcare finances especially in healthcare facilities in urban areas often plagued with financial issues as a baseline.

Introduction of Accountable Care Organizations

An often-overlooked subsection of the Affordable Care Act was the inclusion of legislation to regulate the creation of what is known as Accountable Care Organizations.

> "ACOs were created by sec. 2706 of the Patient Protection and Affordable Care Act to take part in the Medicare Shared Savings Program created under sec. 3022. An ACO, which can include primary care physicians, specialists, hospitals or other providers, bears responsibility jointly for the cost and quality of care delivered to a subset of Original Medicare beneficiaries" ("ACOs (Accountable Care Organizations) - Obamacare Facts", 2017).

The inclusion of creating accountable care organizations was yet another move by the Affordable Care Act in an attempt to control the ever-rising costs of healthcare in the United States. Accountable care organizations are incentivized to produce positive patient care results through monetary means: "If they hit the quality targets, any savings that result are then shared among the providers, on that same token if they miss targets they can end up owing money back to Medicare" ("ACOs (Accountable Care Organizations) - Obamacare Facts", 2017). With the inclusion of accountable care organizations, the Affordable Care Act takes a major step in changing the practices and methodology of providing healthcare in the United States.

How ACOs effect the cost of healthcare

Accountable care organizations are promoted to achieve the best clinical outcomes with the least amount of resources used. In the accountable care organization business model the organizations are not payed in a traditional fee for service sense of services rendered.

> "ACOs get paid based on their patients' medical outcomes rather than on how many tests and procedures they perform. Under the Pioneer model ACOs are paid at fee-for-service rates, but then can earn payments or have to pay-back money based on patient outcomes" ("ACOs (Accountable Care Organizations) - Obamacare Facts", 2017).

This method of basing pay off clinical outcomes incentivizes accountable care organizations to achieve the same end results as normal healthcare facilities while utilizing less resources. When the organization utilizes less ancillary tests or unnecessary practices it saves the healthcare industry money and in effect should have an equal effect on overall healthcare costs at the third-party payer level. When organizations utilize less resources the third-party payers should then in theory save money which will in turn lower the costs of insurance for the average citizen. Due to rising amount of malpractice lawsuits in the American healthcare industry it is often common practice for providers to order unnecessary testing to insulate themselves from the possibility of a malpractice suit. While this may still be a potential risk for accountable care organizations they are monetarily incentivized to utilize less resources on achieving desirable clinical outcomes. Since payments made to accountable care organizations are based off clinical outcomes and not services rendered it behooves the organization to achieve the best possible clinical outcomes while doing the least number of diagnostics to get there.

Reimbursements based on outcomes

Through the advent of accountable care organizations, the Affordable Care Act is attempting to create new avenues of savings within the healthcare industry. In shifting the method of payment from services rendered to a model where outcomes are rewarded it drastically changes the landscape of how medical care is given. This effort to reduce services provided for similar clinical outcomes has been shown to have positive effects on curbing the rising costs of Medicare spending;

> "32 organizations, considered 'Pioneer ACOs', began using the ACO model back in 2012. An independent evaluation report has shown that between 2012 and 2013 the ACO model saved about $300 per Medicare beneficiary for a total of $384 million ($279.7 million in 2012; $104.5 million in 2013)" ("ACOs (Accountable Care Organizations) - Obamacare Facts", 2017).

The method of refocusing services provided into what is the bare minimum in terms of medical necessity to achieve a positive clinical outcome has been successful in lowering the cost of servicing Medicare patients. In regards to directly effecting the cost to service Medicare patients the accountable care organizations initially created after the passage of the Affordable Care Act have proven that this model is effective.

While this method has achieved the goal of lowering cost to Medicare patients it may also inversely affect overall health in patients. Not all testing done for specific medical problems are necessary for that specific diagnosis but may in fact help to create a clearer vision of what ailments the patients have. If services are only rendered based on what is absolutely medically

necessary to understand and alleviate the current issue, then providers may overlook associated and related diagnoses. Ultimately this method of approaching the delivery of healthcare may prove to have an adverse effect on overall health in the communities if underlying issues are not found nor researched. Also, the effect of continuously cycling through the healthcare system by patients will inevitably cause financial issues for organizations that also must adhere to the thirty-day readmission standards of the Affordable Care Act.

Success of accountable care organizations

Accountable care organizations have found a varied degree of success since the original pioneer model began. Unfortunately, the viability of the accountable care organization model is almost matched with its rate of failure. Of the accountable care organizations which found environments in which they prospered, the savings and cost reductions for Medicare were significant: “Still, the authors estimate the Pioneer ACOs generated $280 million in expenditure savings and, if that is sustainable, the ACO model may in fact be able to bend the cost curve” ("ACOs vs. FFS: Spending, Utilization and Patient Experience", 2017). Ultimately, with nearly half of the original batch of accountable care organizations not finding success the cost reductions achieved by the successful accountable care organizations were directly offset by the failures of those who did not continue on with the program. “However, of the original 32 Pioneer ACOs, 13 have left the program, switching to either the MSSP or some other configuration of shared-risk arrangements” ("ACOs vs. FFS: Spending, Utilization and Patient Experience", 2017). The evidence would suggest that while the accountable care organization can be viable the propensity for the initiative to be successful is rather grim.

Potential alternative to fee for service

When examining the accountable care organization model's success in lowering costs for Medicare patients and creating savings, the next area of focus should be determining if the accountable care organization model can be utilized in non-governmental payment programs. This method has produced positive results in the limited number of accountable care organizations that have been established thus far in regards to Medicare spending and the principles could be extended into the private insurance marketplaces.

While the pioneer accountable care organizations have made headway into saving money for Medicare not all accountable care organizations were successful in their attempt:

> "One of the most mentioned reasons for leaving the Pioneer model was the downside risk—payment of penalties for failing to achieve savings. Two others are the complexity of the program and the "churn" (providers, and in some cases patients, returning for more services than are typically needed to achieve the outcome) and "leakage" (when members seek services from non-ACO providers, who often are less able to engage in care coordination)" ("ACOs vs. FFS: Spending, Utilization and Patient Experience", 2017).

With roughly 41% of the pioneer accountable care organizations leaving the program the overall viability of the program is brought into question. While the program did generate savings in the organizations that continued with the program and found a niche of success the success rate was much lower than what can be found acceptable to implement as a broader strategy or alternative to fee for service. If accountable care organizations cannot prevent patients from returning for more services which are not medically necessary to achieve positive clinical outcomes, then the model begins to fail. The entire initiative was created as a measure to curb over utilization of

healthcare resources while still achieving comparable clinical outcomes. If the accountable care organizations do not adhere to utilizing less services while providing care, then they do not receive the financial incentive and thus begin to fail from a financial standpoint. While this model looks promising on a small scale it does not appear to be a healthy alternative to fee for service that is so deeply ingrained in the American way of life. If patients are unwilling to only receive services rendered and not the full scope of what they are accustomed to from modern medicine, then the accountable care organization would continue to fail if implemented as a grand strategy to curb healthcare costs.

Changes to insurance coverage

With the passage of the Affordable Care Act came massive changes to manner in which healthcare coverage is handled in the United States. One such addition to the Affordable Care Act was a provision to add what is being called a "Cadillac tax" to health coverage plans that are deemed too generous in the amount they pay out. Other key changes noted by Hall & McCue (2017);

> "The Affordable Care Act (ACA) created a dramatically different marketplace for individual health insurance through three key reforms: prohibiting insurers from considering subscribers' health status or risk; providing substantial subsidies for millions of people to purchase individual coverage, many for the first time in their lives; and creating an "exchange" structure that facilitates comparison shopping. In addition, the ACA limits the percentage of premiums that insurers can devote to profit and administrative expense and requires state or federal regulators to evaluate the basis for rate increases." (Hall, & McCue, 2017).

The insurance market has forever been changed by the implementation of the Affordable Care Act. Next, we will explore how these changes to insurance markets and new regulations effected both consumers and the healthcare industry as a whole.

Rising premiums post ACA

With the inception of the Affordable Care Act many promises were made to the American people by the Obama administration. As President Obama stated prior to election, "In an Obama administration, we'll lower premiums by up to $2,500 for a typical family per year" (Hall, & II, 2017). At the time of the speech, the American people eagerly welcomed the promise of more affordable healthcare insurance. The upcoming Affordable Care Act would not only extend coverage to millions of Americans which previously were uninsured but also sought to lower insurance premiums at the same time. Unfortunately, as time would tell this campaign promise of the young Illinois senator would never come to fruition.

In modern times the price of healthcare insurance premiums have increased across the board with the severity of the increases seen being the most dramatic in younger individuals. As Gonshorowski (2017) states, "Our findings confirm that younger populations see larger percentage increases in premiums. A state that exhibits this clearly is Vermont, where the increase for 27-year-olds is 144 percent and the increase for 50-year-olds is still 60 percent, but far less. All states exhibit this relationship" (Gonshorowski, 2017). While Arizona, Arkansas and Virginia are amongst the top states with insurance premium hikes, 156.7%, 171.4% and 252.5% respectively, for the 27 year old age group; this trend is seen in almost every state in union. The data shown in appendix E shows the measured changes to insurance premiums based on location and age groups. The fundamental thought process in the creation of the Affordable Care Act and the insurance marketplaces was the fact that young adults would essentially subsidize the costs of

additional elderly and individuals previously uninsurable due to preexisting conditions. With a clear lack of participation in the younger age groups the cost to insure all Americans will continue to rise at rapid rates.

One unfortunate side effect of the Affordable Care Act is how quickly premium costs are rising in the United States. Since the Affordable Care Act has gone into effect the average premium price for a family insurance plan has grown faster than workers' wages have increased (see appendix f). Such dramatic price increases in insurance premiums is putting undue burden on families which were already struggling financially. In 1999 the average percent of family income used for family insurance premiums was 11% as compared to 2017 where the average percent of family income used for insurance premiums is 22% as seen in appendix g.

Additionally, the effects of insurance premium hikes are having a major negative effect on insurers in the Affordable Care Act insurance marketplaces:

> "Even with the higher premiums, insurers are facing losses on ACA policies that are driving many out of the market. One-third of all U.S. counties will have just one insurer. In 2016, a total of 225 counties in the U.S. had only one insurer offering coverage, but that number more than quadrupled to 1,022 in 2017.17 Thirty-three states have fewer insurers offering coverage on the exchanges in 2017 than in 2016. Only one state, Virginia, gained insurers. Five states have only one insurer, while 13 have just two. This is certainly not the competitive market that creators of the ACA envisioned" (Turner 2017).

While many Americans are unable to afford their insurance premiums and suffer loss of healthcare services the third-party insurers are also suffering financially from the effects of the

Affordable Care Act. The further reduction in third-party payers in the insurance marketplaces lead to even greater price hikes as the organizations attempt to stay financially viable in the dwindling marketplace. This in effect leads to higher overall premiums as there is less free market competition between third-party payers and the American people are suffering this burden. When coupled with the increase in insurance deductibles many families cannot afford to get sick as they simply cannot pay for medical care which is a stark contrast from what the Affordable Care Act was trying to achieve.

Effect on Copayments

While the Affordable Care Act has had an extreme effect on the rise of insurance premiums the overall cost of copayments has gone down. As seen in Appendix H the average spending on copayments in 2008 when President Obama took office was approximately 8%. In the final year of the Kaiser Family Foundation analysis, 2014, the spending on copayments had dropped to -26% as seen in Appendix I. This great stride in reducing upfront costs for consumers to achieve healthcare is directly attributed to the Affordable Care Act: “Obamacare has begun to solve the problem by banning copayments on preventive care, such as immunizations, annual wellness visits and screenings for various diseases” ("Rising copays are a barrier to health care, not a spur to efficiency: Bloomberg opinion", 2017). The removal of copays for preventative medical services directly aligns with the vision of how the Affordable Care Act aims to shift the direction of healthcare. Although the reduction in spending on copayments has gone down markedly, the overall effect of the legislation has increased out of pocket costs of healthcare for average Americans.

Rising costs of deductibles

In addition to the cost of insurance premiums rising dramatically, deductibles for insurance plans have also seen a major spike. The healthcare exchanges setup by the Obama administration under the Affordable Care Act allowed families and individuals to purchase health insurance based on coverage versus cost of premiums and deductibles. While this would normally allow for more customization it has set forth an environment which has turned disastrous for the average American. The major driving force in both the skyrocketing costs of premiums and deductibles for said insurance plans is the Affordable Care Act:

> "The real culprit is the Affordable Care Act itself. By mandating that all health-insurance policies cover all manner of treatments — regardless of whether a consumer actually wants or needs them — the law is driving up everyone's costs across the board. Many new enrollees are also sicker than anticipated. And as costs rise, fewer people want the law's plans, which drives prices higher for everyone else. It's a vicious cycle with no end in sight" ("The Latest Problem under the Affordable Care Act: Deductibles", 2017).

The central idea behind raising deductibles is to lower the insurance premium the average user would have to pay monthly. While this may seem like a genuinely decent idea for blue collar workers short on monthly funds it creates a dangerous problem;

> "A December 2015 survey by Bankrate.com found that 63 percent of Americans don't have enough savings to cover an unexpected emergency-room visit costing $1,000. A recent report from the New York Times put it bluntly: Rising out-of-pocket costs have rendered many exchange plans "all but useless" for those already struggling to make ends meet" ("The Latest Problem under the Affordable Care Act: Deductibles", 2017).

If families are forced to choose insurance plans with higher deductibles in the healthcare exchanges because they cannot afford monthly premiums then the family truly cannot afford to seek medical attention with yearly deductibles for families nearing $15,000. Many Americans are now technically "covered" under insurance plans as reflected by the numbers of newly insured by the Affordable Care Act but are incapable of using their plans.

Results of price increases

As a direct result of increasing prices in nearly all factors associated with health insurance the industry is struggling. Premiums have risen over time under the Affordable Care Act to a price point where families and individuals find it more economical to pay out of pocket for services or hope they that they never get sick during the year. While this is dangerous in the fact that if something major were to happen to the individual and insurance was not currently held it would essentially bankrupt the person or family it also plays a role in the failing health insurance marketplaces. With the general idea of insurance marketplaces under the Affordable Care Act being the younger and healthier generation essentially subsidizing the cost of those with preexisting conditions or elderly with more medical issues it sets the entire system into a death spiral. Since premiums are rising to cover the costs of the extremely sick now being insured it is causing younger Americans to not participate in the system which further exacerbates the problem. With little to no young healthy individuals participating in the insurance marketplaces it causes the insurance premiums of those who do participate to rise even further to cover the costs associated with caring for those with major medical issues. This cycle is set to continue to spiral out of control until the system no longer works. As seen in recent years many insurers are dropping out of the Affordable Care Act insurance marketplaces as they

cannot bear the financial burden which in turn leaves individuals uninsured or scrambling to find another plan to adhere to and continue the chain of paying exorbitant fees for terrible coverage.

In addition to outrageous premiums hikes over the course of the Affordable Care Act, the American public is now having to contend with the overwhelming majority of insurance plans converting to high deductible models. While premiums skyrocket out of control the only manner in which the average blue collar American worker can afford insurance is to sign onto lower priced higher premium insurance plans referred to as “bronze” plans in the Affordable Care Act insurance marketplaces. While this in and of itself is not a major detracting factor the extremely high deductibles are. If a family of four purchases a bronze plan under the insurance marketplace and struggles to pay their monthly premium in the range of $600 to $1000 it is not remotely feasible for the aforementioned family to be expected to pay a deductible that often times approaches $15,000. This loophole that the Obama administration counts as successfully insuring individuals that were previously uninsured does not adhere to common sense. If the family or individual is forced under law to retain healthcare insurance but is completely incapable of receiving care due to unachievably high deductibles then essentially, they are paying a monthly fee so as to not have to endure the mandated tax stamp. This apparent oversight by the Obama administration and the Affordable Care Act leaves the American public in a much worse condition than before the inception of the law.

While the American people suffer under the new rules and regulations of the Affordable Care Act regarding insurance price hikes the healthcare industry is equally effected. The instances of bad debts are surely to climb as more individuals deny healthcare coverage due to steep insurance premiums and even higher deductibles. While initially this may not have any

apparent effect on the healthcare industry it is when these individuals acquire catastrophic medical issues that the problem arises. As Turner (2017), finds that;

> "The ACA imposes tax penalties on Americans who do not purchase compliant health coverage. IRS reports that for the 2015 tax year, 6.5 million people paid $3 billion in penalties. 6 Another 12.7 million claimed an exemption from the individual mandate penalty.7 These 19 million people clearly are saying the health insurance the federal government is requiring them to purchase is too expensive or not a good value for the cost they are required to pay. Far too many of them are the younger, healthier people that we most need in the insurance pools to make them solvent" (Turner 2017).

Americans are forgoing insurance to attempt to save what little money they have and in the event of emergency or catastrophic event they will be uninsured and the healthcare industry will inevitable have to bear the burden financially. This will further drive up the bad debts and charity care that must be endured by healthcare organizations eventually leading smaller or rural hospitals to reach financial failure.

Future of the Affordable Care Act

With newly elected republican President Trump comes a new era of healthcare reform. Since the inception of the Affordable Care Act the Republican party in the United States has called for repealing of the Affordable Care Act and replacement with another bill. This new administration has made campaign promises before election to both repeal and replace the Affordable Care Act with another bill which would benefit those disparaged by ineffectiveness of the healthcare marketplaces and the ever-rising premiums and deductibles for insurance plans. With sweeping changes on the horizon the future of the healthcare industry is set to change once

again both in the manner in which the healthcare industry operates and the financial stability of healthcare organizations across the United States.

Effect of Repeal

With the election of President Trump one could assume that he will make good on his campaign promises to both repeal and replace the Affordable Care Act. The first piece of legislation brought forth by the Republican party in an effort to repeal and replace the Affordable Care Act was known as the American Health Care Act or AHCA for short. Oberlander (2017) states the probable effects of this legislation should it have passed:

> "The House Republican bill would have badly eroded insurance coverage, substantially raised the costs of individual plans for older Americans, and made insurance benefits less generous, increasing consumers' out-of-pocket expenses. It proposed deep cuts both in Medicaid spending, including tight caps on federal payments to the states, and in financial help for low-income Americans buying private insurance, while giving higher-income Americans and the health care industry large tax cuts" (Oberlander 2017).

While no piece of legislation, especially concerning healthcare, is without its faults the American Health Care Act was perceived as a massive failure by both the American public and the house representatives set to vote on the bill. As such, the American Health Care Act failed to gain enough momentum while being voted on in the House of Representatives and the bill was summarily pulled from voting. Although the Affordable Care Act has been damaging on many factors of the healthcare industry there have also been many benefits, especially newly insured under the bill which cannot so easily be undone now. Additional effects of the American Health Care Act and a comparison to the Affordable Care Act can be seen in appendix J. With any hope of passing new

legislation to replace the Affordable Care Act both parties must come to agreement on a bill that not only accepts the portions of the bill that are working as intended and helping the American public but also to fix the areas which were left in oversight to eventually become problematic or cause widespread failure i.e. insurance marketplaces.

Potential outcomes of repealing the Affordable Care Act

The most hopeful outcome of repealing and replacing the Affordable Care Act would be one of retaining the portions of the bill that help the average American while also fixing the broken insurance marketplaces and other effects that undermine the financial stability of the healthcare industry. While extending coverage to additional indigent Americans and coverage for individuals with preexisting conditions was a prolific step forward for the Affordable Care Act, these successes have been overshadowed by the insurmountable failures in insurance marketplaces and the effects of such failure. If the Republican party can come to agreement on legislation which keeps the portions of the Affordable Care Act Americans find agreeable while fixing the inherently broken insurance marketplaces then and only then will a viable replacement for the Affordable Care Act be achieved.

Recommendations

With a new presidency comes a chance to change the face of healthcare once again. Although the Affordable Care Act has made great strides towards ensuring all Americans have healthcare coverage it has fallen short on many areas which make the bill inadequate for the needs of the American people. With repeal and replacement of the Affordable Care Act looming on the horizon the next logical step is finding a viable common ground between the old and new legislation. The most prominent aspect of the healthcare industry under the Affordable Care Act

which must be fixed is the insurance marketplace and the interactions between the consumer and insurance companies. Under the current model young and healthy individuals are not incentivized to participate in the healthcare insurance marketplace and as such often do not. This leads to a cascading effect of higher insurance premiums which in turn exacerbates the issue of few younger individuals participating. While allowing individuals with preexisting conditions to attain insurance plans was helpful to those individuals it placed undo financial hardship on third-party payers who the extended the price adjustments to all other demographics in an effort to subsidize the most lost for critically ill newly insured patients. With this in mind the insurance marketplaces must be given an environment where they can become prosperous once again and not rely on younger generations to bear the weight of the sickly.

Societal needs

When looking at the downward spiral of American healthcare a pragmatic mind must eventually lead to the acceptance of socialized medicine for the United States. While the Affordable Care Act was touted by many as a first step in the direction of socialized medicine it was not directly intended to be. The failures of the Affordable Care Act have driven insurance marketplaces into failure and created an environment where even those who carry insurance are unable to utilize it. With this in mind the system only appears to be getting worse, both for the American public and the financial stability of the healthcare industry. Seemingly the only manner in which to save both the American people and healthcare industry from bankruptcy would be the implementation of socialized medicine. Unfortunately, the American people are not prepared for the ramifications of socialized medicine in practice and will need adjustment from the imperfect market of modern healthcare. While the American public will have a difficult time adjusting to changes for socialized medicine it is the only viable pathway towards lowering

medical related spending in the United States. Socialized medicine is one of the only perceivable methods that can save the current healthcare industry through rationing of services, regulation of pharmaceutical costs and properly adjusted rates for reimbursement through a government service. Only with strict regulation on both costs and services provided can the American healthcare system be saved from financial disaster.

Cost Controls

Under the Affordable Care Act provisions were instated in an attempt to control costs across the healthcare industry. Accountable Care Organizations were created to incentivize organizations to cut costs by only prescribing the necessary treatments for any given diagnoses. Unfortunately, ACOs were unable to find an overwhelming effect on the cost of healthcare in their limited run and only a select few were able to overcome the hardships of the new venture and continue with business. The most prominent change the healthcare industry needs in order to become financially stable is answered either one of two ways. The healthcare marketplace must either be deregulated so that free market principles can influence the pricing of healthcare functions or the federal government must fully regulate the healthcare industry through socialized medicine. The current model of insulating consumers from the cost of healthcare and overall lack of education in their own diagnosis is a direct cause of inflation of services. If patients are insulated from the full costs of healthcare then they tend to over utilize healthcare resources which in turn drives the price for the community upwards. This is especially troublesome when coupled with the newly insured whom are far more sickly than the Obama administration accounted for when extending insurance benefits to this group of individuals. Without choice both in insurers and information in which facilities provide services for various costs the consumer is pigeon holed into choosing services based on locality rather than

affordability. Conversely, if the federal government chooses to regulate healthcare entirely this would place necessary limitations on the costs companies are allowed to charge for services. This measure would eliminate price gouging from pharmaceutical companies and allow American citizens to no longer pay exorbitant fees for both premiums and deductibles but rather a tax rate on their yearly income which once all Americans participate would be much lower than current costs for healthcare per capita (see appendix k). Currently Americans pay almost double the cost per capita of other developed nations for the healthcare they receive. Although the Affordable Care Act attempted to alleviate these issues it only further exacerbated the financial difficulties of not only the middle class of the United States but also greatly damaged the financial stability of the healthcare industry as a whole. Only through either socialized medicine or education and the existence of a completely free market in healthcare can the industry hope to recover from the financial damages of the Affordable Care Act.

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Appendix A

Table 3. Total Federal and State Medicaid Expenditures [1] Under the ACA with All States Expanding Medicaid [2] Compared to No ACA, 2013 - 2022 (millions)

	Expenditure Under No ACA			Expenditure Under ACA with All States Expanding Medicaid [2]			Change in Expenditure Relative to No ACA					
	Federal ($)	State ($)	Total ($)	Federal ($)	State ($)	Total ($)	Federal Δ ($)	State Δ ($)	Total Δ ($)	Federal Δ (%)	State Δ (%)	Total Δ (%)
US TOTAL	3,659,010	2,679,790	6,338,799	4,611,463	2,756,269	7,367,732	952,454	76,479	1,028,933	26.0%	2.9%	16.2%
Regional Totals [3]												
New England	217,415	190,369	407,784	249,607	185,666	435,273	32,192	-4,703	27,489	14.8%	-2.5%	6.7%
Middle Atlantic	811,469	738,200	1,549,669	976,317	727,019	1,703,336	164,849	-11,181	153,667	20.3%	-1.5%	9.9%
East North Central	532,092	338,477	870,569	677,776	357,673	1,035,449	145,684	19,196	164,880	27.4%	5.7%	18.9%
West North Central	248,104	178,343	426,447	296,777	184,959	481,736	48,673	6,616	55,289	19.6%	3.7%	13.0%
South Atlantic	497,582	303,061	800,643	696,075	324,902	1,020,978	198,493	21,841	220,335	39.9%	7.2%	27.5%
East South Central	258,502	110,195	368,697	333,532	116,555	450,087	75,031	6,360	81,391	29.0%	5.8%	22.1%
West South Central	377,589	238,498	616,087	493,998	252,153	746,151	116,408	13,655	130,063	30.8%	5.7%	21.1%
Mountain	213,727	115,553	329,280	269,960	123,598	393,558	56,233	8,046	64,278	26.3%	7.0%	19.5%
Pacific	502,530	467,094	969,624	617,421	483,744	1,101,165	114,891	16,650	131,541	22.9%	3.6%	13.6%
State Totals												
Alabama	52,137	22,791	74,929	67,521	24,071	91,592	15,384	1,280	16,664	29.5%	5.6%	22.2%
Alaska	11,599	9,557	21,156	13,236	9,883	23,118	1,637	325	1,962	14.1%	3.4%	9.3%
Arizona	73,273	34,711	107,984	90,554	37,848	128,401	17,280	3,137	20,417	23.6%	9.0%	18.9%
Arkansas	42,494	16,825	59,319	55,681	18,046	73,726	13,186	1,221	14,407	31.0%	7.3%	24.3%
California	379,409	366,840	746,250	464,016	380,810	844,826	84,607	13,970	98,576	22.3%	3.8%	13.2%
Colorado	31,518	29,657	61,175	43,086	31,154	74,239	11,568	1,496	13,064	36.7%	5.0%	21.4%
Connecticut	45,962	43,419	89,381	55,954	43,068	99,022	9,992	-351	9,641	21.7%	-0.8%	10.8%
Delaware	12,503	9,433	21,937	15,228	8,928	24,157	2,725	-505	2,220	21.8%	-5.4%	10.1%
District of Columbia	19,846	7,893	27,739	20,836	8,019	28,854	990	126	1,116	5.0%	1.6%	4.0%
Florida	146,971	111,964	258,935	220,266	120,849	341,114	73,294	8,885	82,179	49.9%	7.9%	31.7%
Georgia	84,211	41,374	125,585	122,153	44,512	166,665	37,942	3,139	41,080	45.1%	7.6%	32.7%
Hawaii	12,142	10,626	22,768	15,917	10,758	26,675	3,775	132	3,907	31.1%	1.2%	17.2%
Idaho	17,218	6,640	23,858	20,967	6,901	27,868	3,749	261	4,010	21.8%	3.9%	16.8%
Illinois	127,178	122,847	250,024	156,621	129,279	285,900	29,443	6,433	35,876	23.2%	5.2%	14.3%
Indiana	69,777	33,130	102,907	88,698	34,515	123,212	18,920	1,385	20,305	27.1%	4.2%	19.7%
Iowa	34,293	20,657	54,950	39,722	20,335	60,058	5,430	-321	5,108	15.8%	-1.6%	9.3%
Kansas	27,886	19,691	47,577	34,582	20,734	55,316	6,696	1,043	7,739	24.0%	5.3%	16.3%
Kentucky	63,441	24,831	88,271	82,173	26,404	108,577	18,732	1,574	20,306	29.5%	6.3%	23.0%
Louisiana	62,963	38,737	101,700	79,708	40,515	120,223	16,745	1,778	18,523	26.6%	4.6%	18.2%
Maine	26,920	14,682	41,602	30,432	14,246	44,677	3,512	-436	3,076	13.0%	-3.0%	7.4%
Maryland	55,564	53,690	109,254	69,064	53,187	122,250	13,500	-504	12,996	24.3%	-0.9%	11.9%
Massachusetts	100,045	96,223	196,268	111,599	92,209	203,808	11,553	-4,014	7,539	11.5%	-4.2%	3.8%
Michigan	105,103	51,557	156,661	130,659	55,583	186,242	25,556	4,026	29,581	24.3%	7.8%	18.9%
Minnesota	73,633	71,324	144,957	80,688	73,255	153,943	7,055	1,931	8,986	9.6%	2.7%	6.2%
Mississippi	47,520	15,749	63,269	63,188	16,949	80,138	15,668	1,201	16,869	33.0%	7.6%	26.7%
Missouri	75,647	42,108	117,754	96,610	44,906	141,515	20,963	2,798	23,761	27.7%	6.6%	20.2%
Montana	10,555	4,694	15,249	13,370	5,130	18,500	2,815	436	3,250	26.7%	9.3%	21.3%
Nebraska	19,750	14,005	33,755	23,162	14,522	37,685	3,412	518	3,930	17.3%	3.7%	11.6%
Nevada	14,904	10,548	25,453	21,525	11,745	33,270	6,620	1,197	7,817	44.4%	11.3%	30.7%
New Hampshire	13,078	11,657	24,735	15,736	11,972	27,709	2,659	315	2,974	20.3%	2.7%	12.0%
New Jersey	87,540	83,923	171,463	107,339	87,299	194,637	19,799	3,375	23,174	22.6%	4.0%	13.5%
New Mexico	38,064	16,081	54,144	43,758	16,688	60,446	5,694	608	6,302	15.0%	3.8%	11.6%
New York	468,498	450,977	919,475	552,992	433,308	986,300	84,494	-17,669	66,825	18.0%	-3.9%	7.3%
North Carolina	127,286	65,988	193,273	171,996	71,086	243,082	44,710	5,098	49,808	35.1%	7.7%	25.8%
North Dakota	7,748	5,142	12,890	10,642	5,598	16,241	2,895	456	3,351	37.4%	8.9%	26.0%
Ohio	165,732	90,473	256,205	223,742	97,100	320,842	58,010	6,627	64,637	35.0%	7.3%	25.2%
Oklahoma	44,197	23,989	68,186	53,344	25,010	78,354	9,147	1,021	10,168	20.7%	4.3%	14.9%
Oregon	38,320	21,284	59,604	53,027	22,087	75,113	14,707	803	15,509	38.4%	3.8%	26.0%
Pennsylvania	167,518	132,284	299,802	210,859	136,278	347,138	43,341	3,995	47,336	25.9%	3.0%	15.8%
Rhode Island	19,375	16,507	35,882	22,527	16,957	39,484	3,152	450	3,602	16.3%	2.7%	10.0%
South Carolina	53,227	21,715	74,942	70,230	23,242	93,472	17,003	1,527	18,530	31.9%	7.0%	24.7%
South Dakota	9,148	5,416	14,563	11,370	5,608	16,978	2,222	192	2,415	24.3%	3.6%	16.6%
Tennessee	95,404	46,824	142,228	120,650	49,130	169,780	25,247	2,306	27,552	26.5%	4.9%	19.4%
Texas	227,935	158,947	386,882	305,266	168,582	473,848	77,330	9,636	86,966	33.9%	6.1%	22.5%
Utah	21,989	8,295	30,284	28,996	9,002	37,998	7,007	707	7,714	31.9%	8.5%	25.5%
Vermont	12,035	7,880	19,916	13,359	7,214	20,573	1,324	-667	657	11.0%	-8.5%	3.3%
Virginia	52,220	50,066	102,286	68,633	52,682	121,316	16,413	2,616	19,029	31.4%	5.2%	18.6%
Washington	61,060	58,786	119,846	71,226	60,206	131,432	10,166	1,420	11,586	16.6%	2.4%	9.7%
West Virginia	33,667	11,955	45,622	42,798	12,531	55,329	9,131	576	9,707	27.1%	4.8%	21.3%
Wisconsin	64,302	40,471	104,773	78,057	41,196	119,253	13,755	725	14,480	21.4%	1.8%	13.8%
Wyoming	6,205	4,927	11,132	7,705	5,131	12,836	1,500	204	1,704	24.2%	4.1%	15.3%

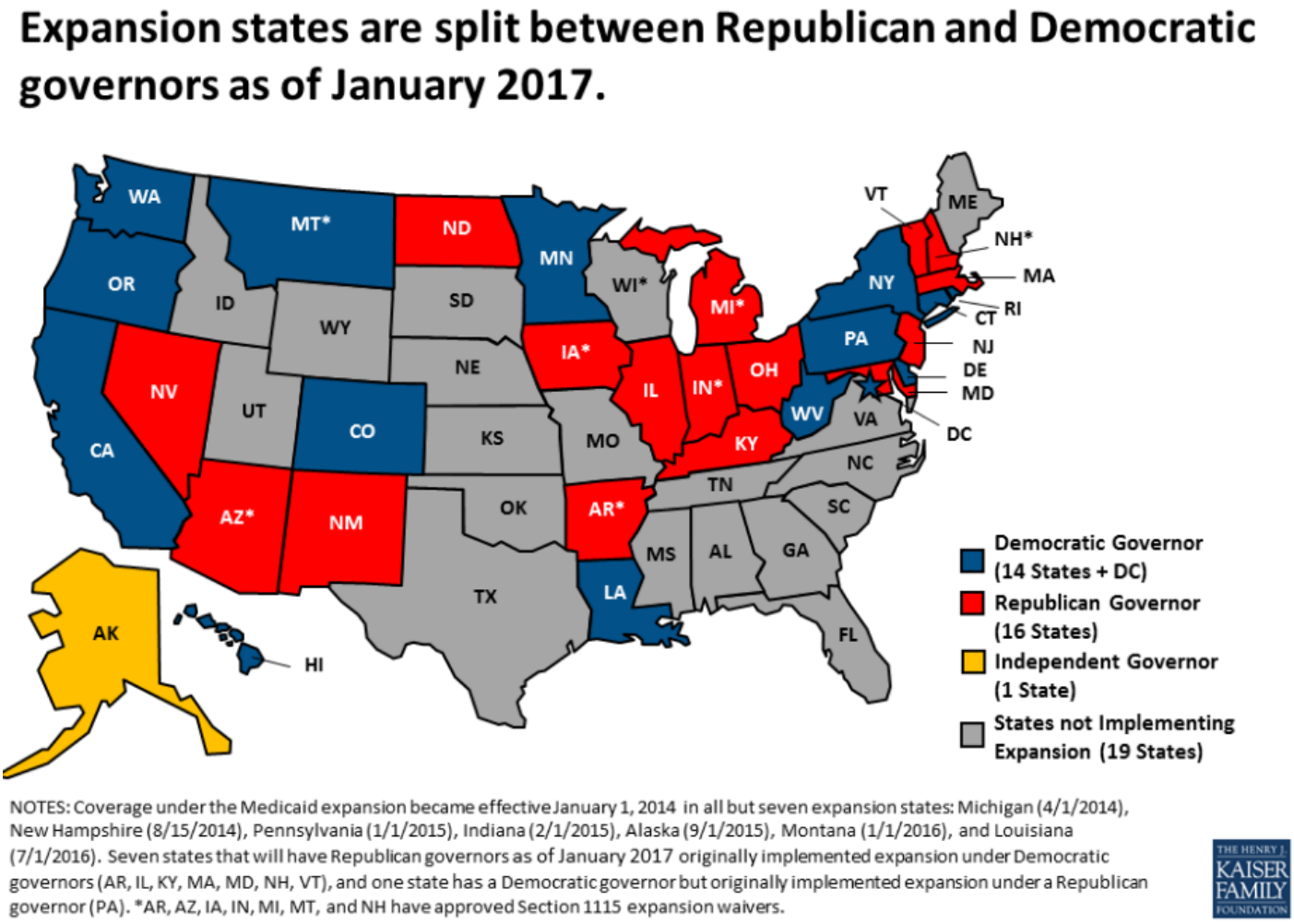
Source: Urban Institute Analysis, HIPSM 2012

1. Includes all Medicaid spending in baseline including aged, long term care, DSH, etc.

2. Also includes expenditure increases that would have occurred under the ACA without the Medicaid expansion

3. The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes DE, DC, MD, NJ, NY, and PA. The East North Central region includes IL, IN, MI, OH, and WI. The West North Central region includes IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes FL, GA, NC, SC, VA, and WV. The East South Central region includes AL, KY, MS, and TN. The West South Central region includes AR, LA, OK,and TX. The Mountain region includes AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes AK, CA, HI, OR and WA.

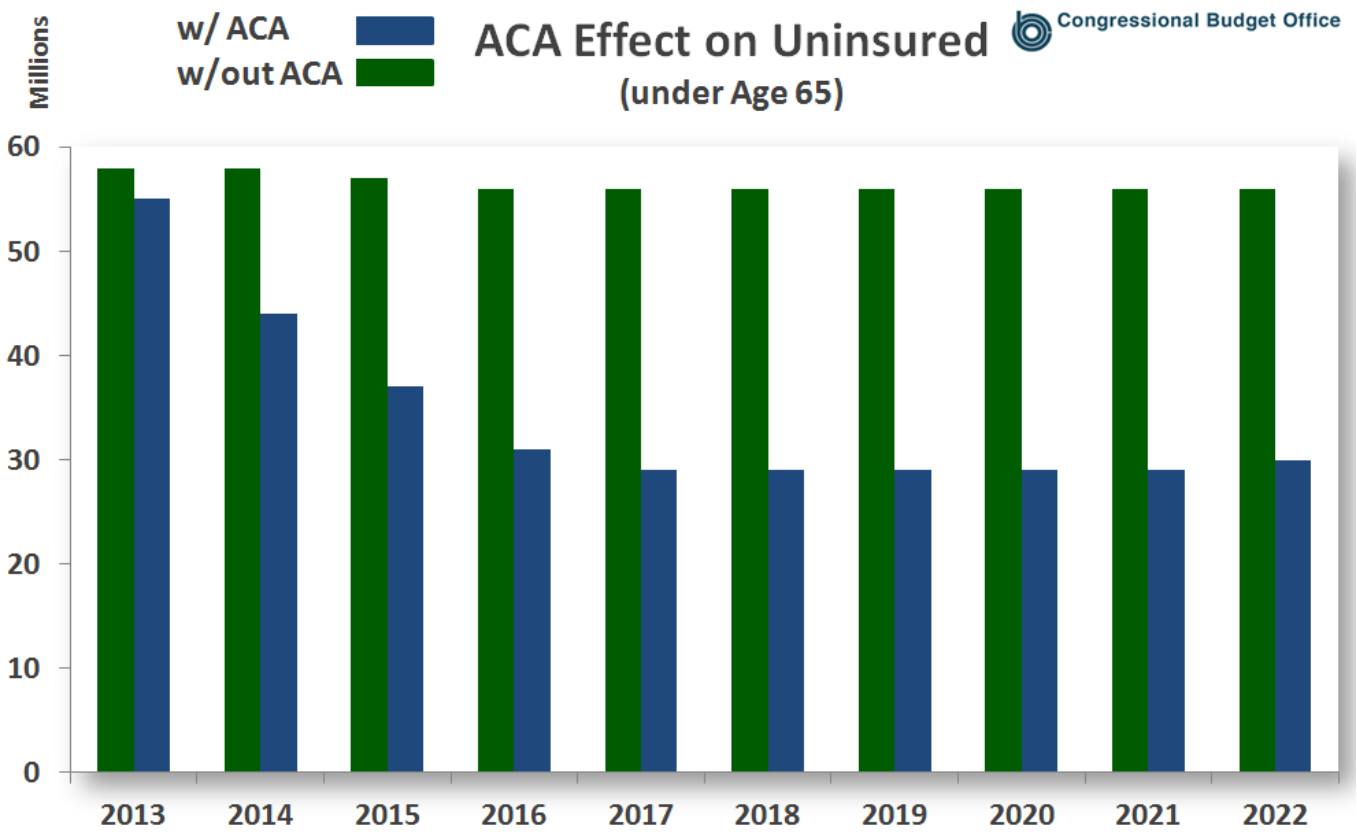
Appendix B



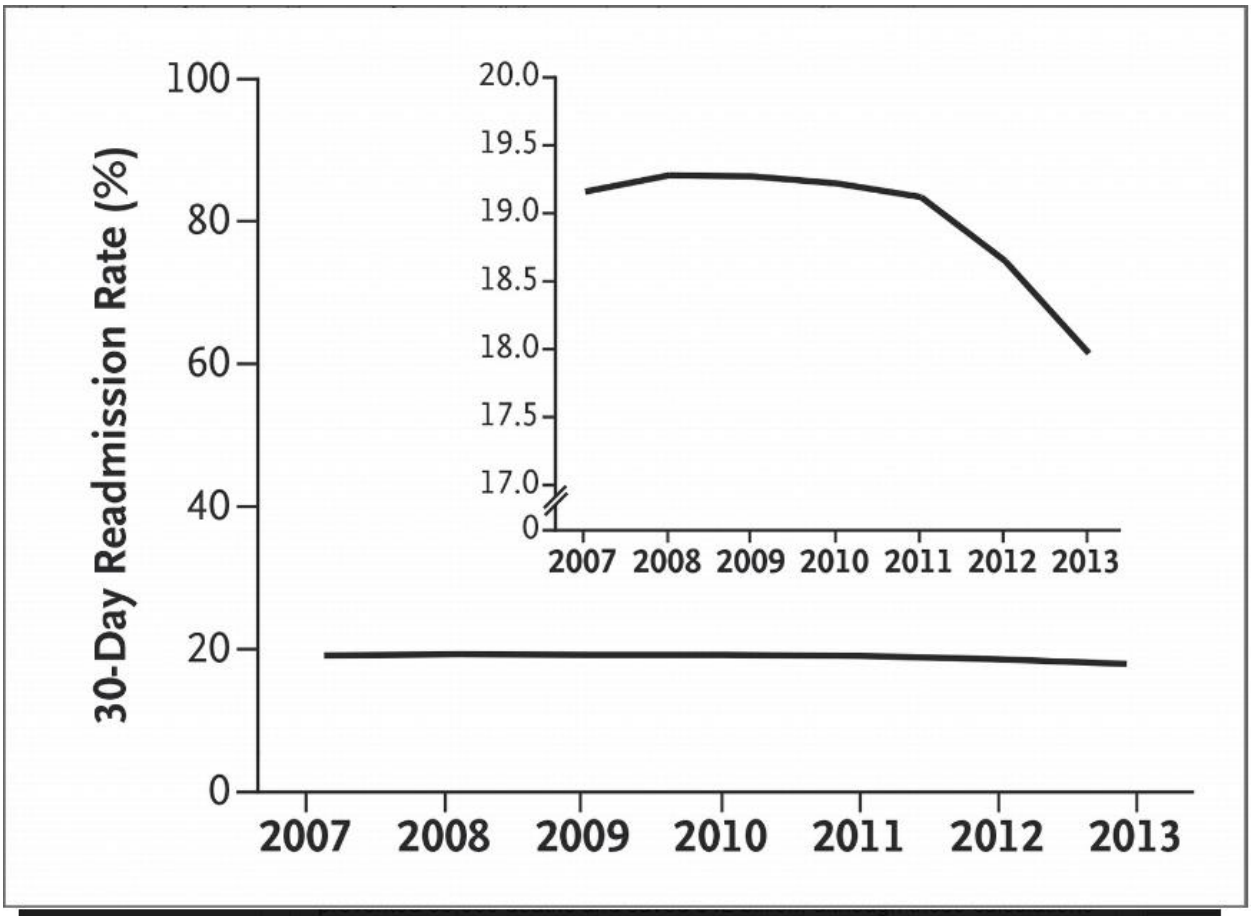
NOTES: Coverage under the Medicaid expansion became effective January 1, 2014 in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016). Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.

THE HENRY J. KAISER FAMILY FOUNDATION

Appendix C


Millions
w/ ACA
w/out ACA
ACA Effect on Uninsured
(under Age 65)
Congressional Budget Office
60
50
40
30
20
10
0
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

Appendix D



All-Cause, 30-Day Hospital Readmission Rate among Medicare Beneficiaries.

Appendix E

TABLE 1

Comparing the Costs of Buying Health Insurance

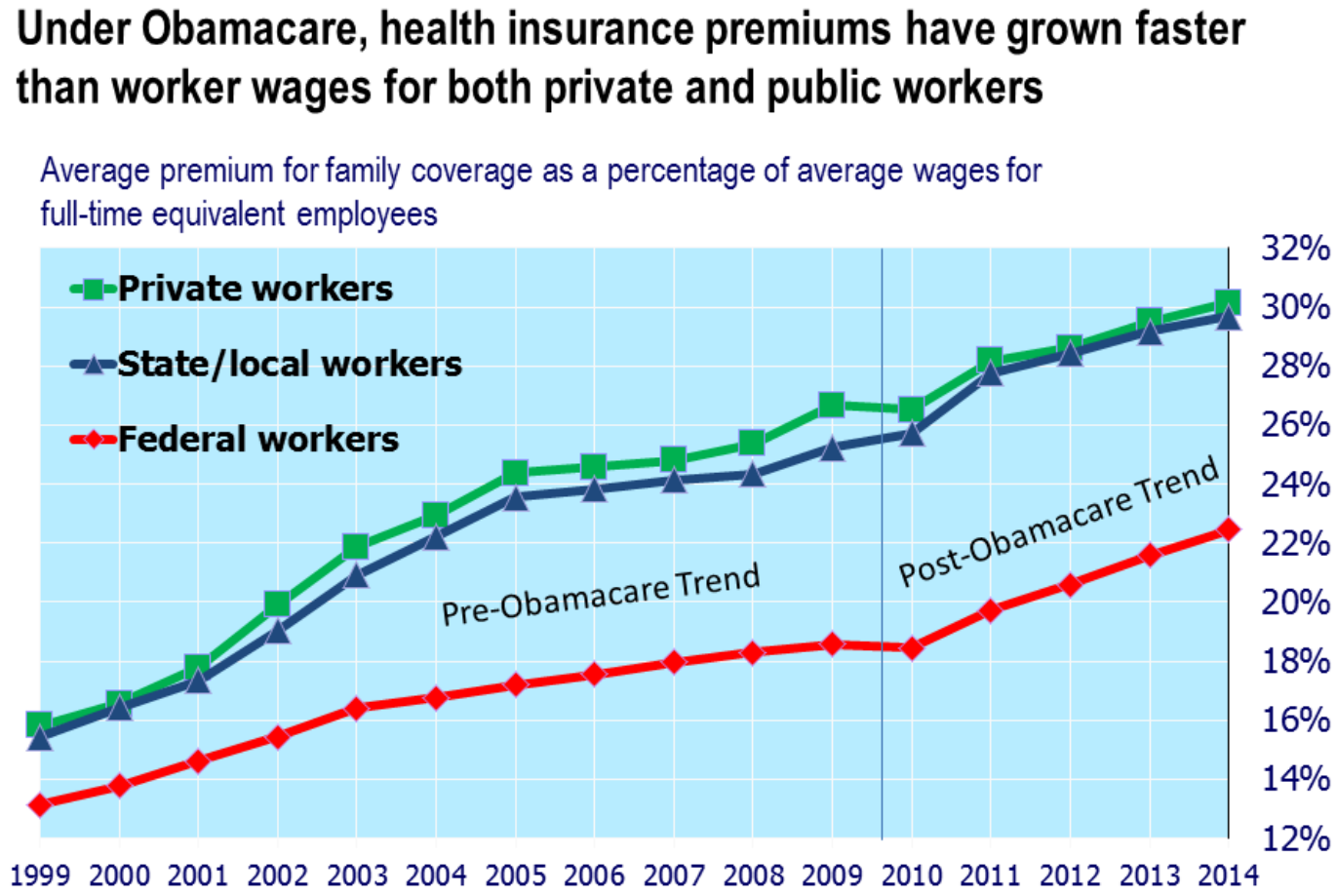
*This table shows the average **one-month premium change** in buying health insurance in the non-group market versus the Obamacare exchanges.*

Up 100%+
Up 51%–100%
Up 26%–50%
Up 0%–25%
Down

	ADULT AGE 27			ADULT AGE 50			FAMILY OF FOUR		
	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change
Alabama	$165.00	$216.12	31.0%	$285.00	$368.31	29.2%	$676.66	$730.01	7.9%
Alaska	$198.00	$341.58	72.5%	$398.00	$582.05	46.2%	$1,020.45	$1,153.84	13.1%
Arizona	$102.00	$261.87	156.7%	$315.00	$446.24	41.7%	$792.38	$884.51	11.6%
Arkansas	$105.00	$285.00	171.4%	$215.00	$385.00	79.1%	$761.26	$948.82	24.6%
California	$174.00	$215.00	23.6%	$225.00	$255.00	13.3%	$860.33	$890.00	3.4%
Colorado	$275.00	$192.35	-30.1%	$330.00	$245.00	-25.8%	$1,024.36	$962.39	-6.0%
Connecticut	$149.37	$245.27	64.2%	$249.00	$435.00	74.7%	$802.68	$987.00	23.0%
Delaware	$129.35	$258.60	99.9%	$267.00	$440.71	65.1%	$731.44	$873.52	19.4%
District of Columbia	$153.27	$155.00	1.1%	$225.00	$345.00	53.3%	$545.13	$629.00	15.4%
Florida	$151.40	$264.45	74.7%	$257.00	$450.67	75.4%	$724.98	$893.27	23.2%
Georgia	$98.12	$263.28	168.3%	$263.00	$448.69	70.6%	$732.34	$889.32	21.4%
Idaho	$92.45	$172.35	86.4%	$262.00	$351.00	34.0%	$624.08	$682.00	9.3%
Illinois	$116.45	$249.72	114.4%	$298.00	$425.56	42.8%	$753.23	$843.50	12.0%
Indiana	$197.45	$264.77	34.1%	$249.00	$451.21	81.2%	$712.80	$894.38	25.5%
Iowa	$205.00	$230.21	12.3%	$347.00	$392.32	13.1%	$729.00	$777.61	6.7%
Kansas	$87.40	$200.14	129.0%	$198.00	$341.08	72.3%	$553.92	$676.05	22.0%
Louisiana	$129.20	$266.38	106.2%	$315.00	$453.96	44.1%	$800.56	$899.79	12.4%
Maine	$225.00	$282.59	25.6%	$329.00	$341.00	3.6%	$945.86	$954.57	0.9%
Maryland	$129.00	$142.00	10.1%	$243.00	$275.00	13.2%	$593.79	$614.00	3.4%
Michigan	$117.30	$255.85	118.1%	$305.00	$436.01	43.0%	$771.41	$864.22	12.0%
Minnesota	$106.00	$122.00	15.1%	$216.00	$265.00	22.7%	$716.90	$760.00	6.0%
Mississippi	$163.00	$213.00	30.7%	$364.00	$500.00	37.4%	$854.92	$943.00	10.3%
Missouri	$159.00	$244.06	53.5%	$299.00	$415.92	39.1%	$743.80	$824.39	10.8%
Montana	$150.00	$213.80	42.5%	$278.00	$364.35	31.1%	$666.11	$722.19	8.4%
Nebraska	$125.00	$213.34	70.7%	$298.00	$363.57	22.0%	$680.98	$720.62	5.8%
Nevada	$168.00	$172.00	2.4%	$297.00	$445.00	49.8%	$620.00	$625.00	0.8%
New Hampshire	$220.00	$221.71	0.8%	$359.00	$377.84	5.2%	$739.09	$748.91	1.3%
New Jersey	$329.00	$319.33	-2.9%	$550.00	$544.20	-1.1%	$1,081.50	$1,078.66	-0.3%
New Mexico	$105.00	$189.00	80.0%	$315.00	$354.00	12.4%	$822.72	$849.00	3.2%
New York	$500.00	$356.00	-28.8%	$500.00	$356.00	-28.8%	$763.26	$712.00	-6.7%
North Carolina	$135.00	$257.39	90.7%	$364.00	$438.64	20.5%	$824.85	$869.41	5.4%
North Dakota	$116.00	$247.30	113.2%	$215.00	$421.44	96.0%	$634.81	$835.33	31.6%
Ohio	$247.00	$243.12	-1.6%	$421.00	$414.32	-1.6%	$824.47	$821.21	-0.4%
Oklahoma	$135.00	$213.02	57.8%	$298.00	$363.02	21.8%	$680.29	$719.53	5.8%
Oregon	$115.00	$178.20	55.0%	$201.00	$215.90	7.4%	$676.65	$689.43	1.9%
Pennsylvania	$167.00	$220.36	32.0%	$289.00	$374.05	29.4%	$689.38	$744.13	7.9%
Rhode Island	$285.00	$205.00	-28.1%	$354.00	$297.00	-16.1%	$834.42	$802.13	-3.9%
South Carolina	$205.00	$246.19	20.1%	$315.00	$419.56	33.2%	$762.59	$831.60	9.0%
South Dakota	$159.00	$308.64	94.1%	$305.00	$525.99	72.5%	$853.71	$1,042.56	22.1%
Tennessee	$135.00	$214.70	59.0%	$278.00	$365.90	31.6%	$667.91	$725.24	8.6%
Texas	$115.00	$229.95	100.0%	$205.00	$391.88	91.2%	$599.72	$776.74	29.5%
Utah	$126.00	$220.91	75.3%	$268.00	$338.04	26.1%	$648.54	$693.88	7.0%
Vermont	$150.00	$366.00	144.0%	$250.00	$402.00	60.8%	$682.64	$805.00	17.9%
Virginia*	$165.00	$581.55	252.5%	$278.00	$991.03	256.5%	$704.76	$1,964.29	178.7%
Washington	$124.00	$215.00	73.4%	$314.00	$355.00	13.1%	$720.68	$745.00	3.4%
West Virginia	$215.00	$229.48	6.7%	$359.00	$391.07	8.9%	$757.83	$775.14	2.3%
Wisconsin	$140.00	$277.91	98.5%	$289.00	$473.61	63.9%	$788.82	$938.72	19.0%
Wyoming	$289.00	$364.95	26.3%	$540.00	$621.96	15.2%	$1,186.00	$1,232.78	3.9%

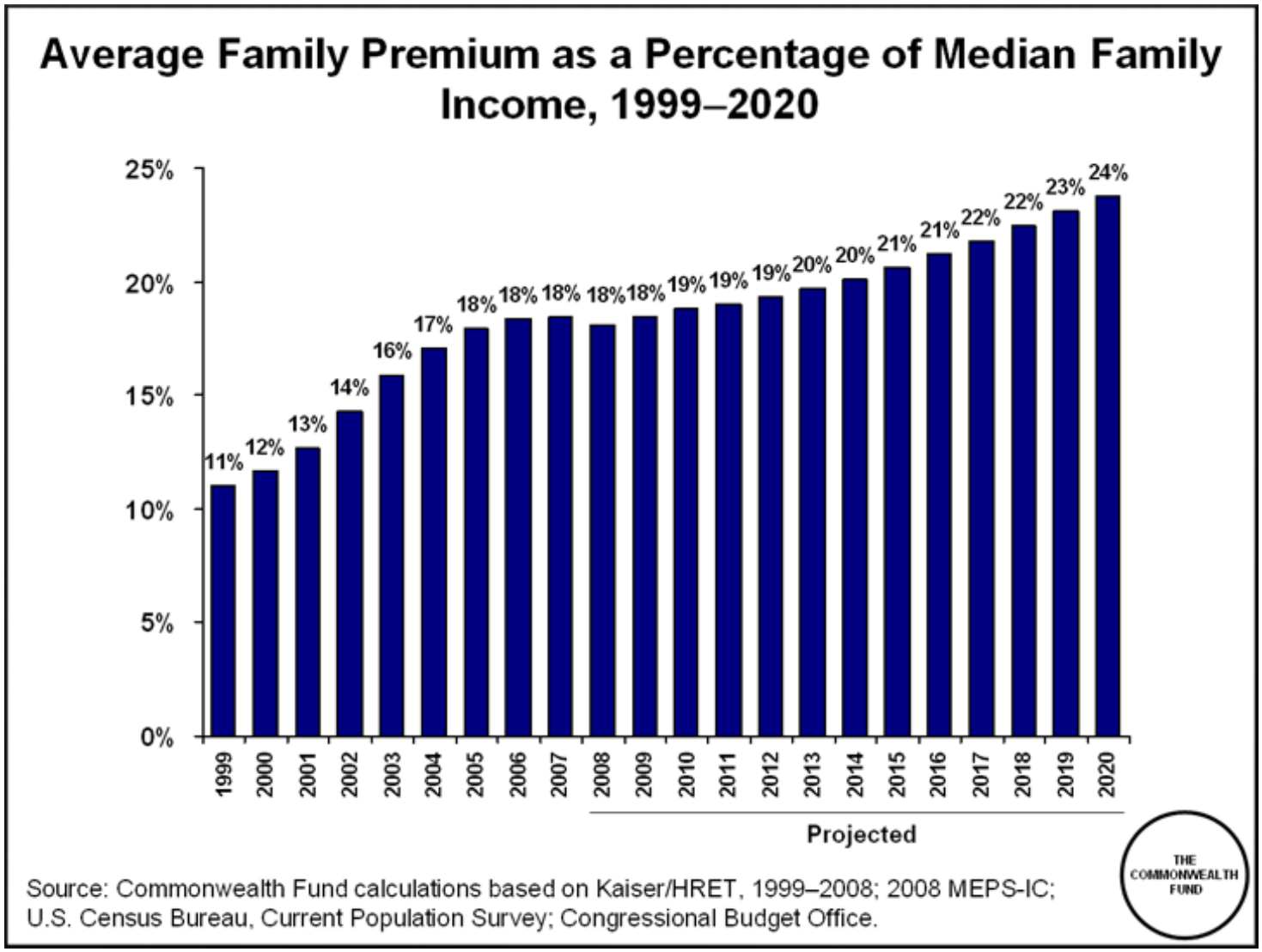
* Virginia figures are as reported. However, errors are likely leading to higher expected premiums.
Note: Hawaii, Massachusetts, and Kentucky are not included in this table due to unavailable data.
Sources: Heritage Foundation calculations using the Heritage Health Insurance Microsimulation Model, exchange premium data from healthcare.gov, and state-run exchange data from state press releases.

Appendix F

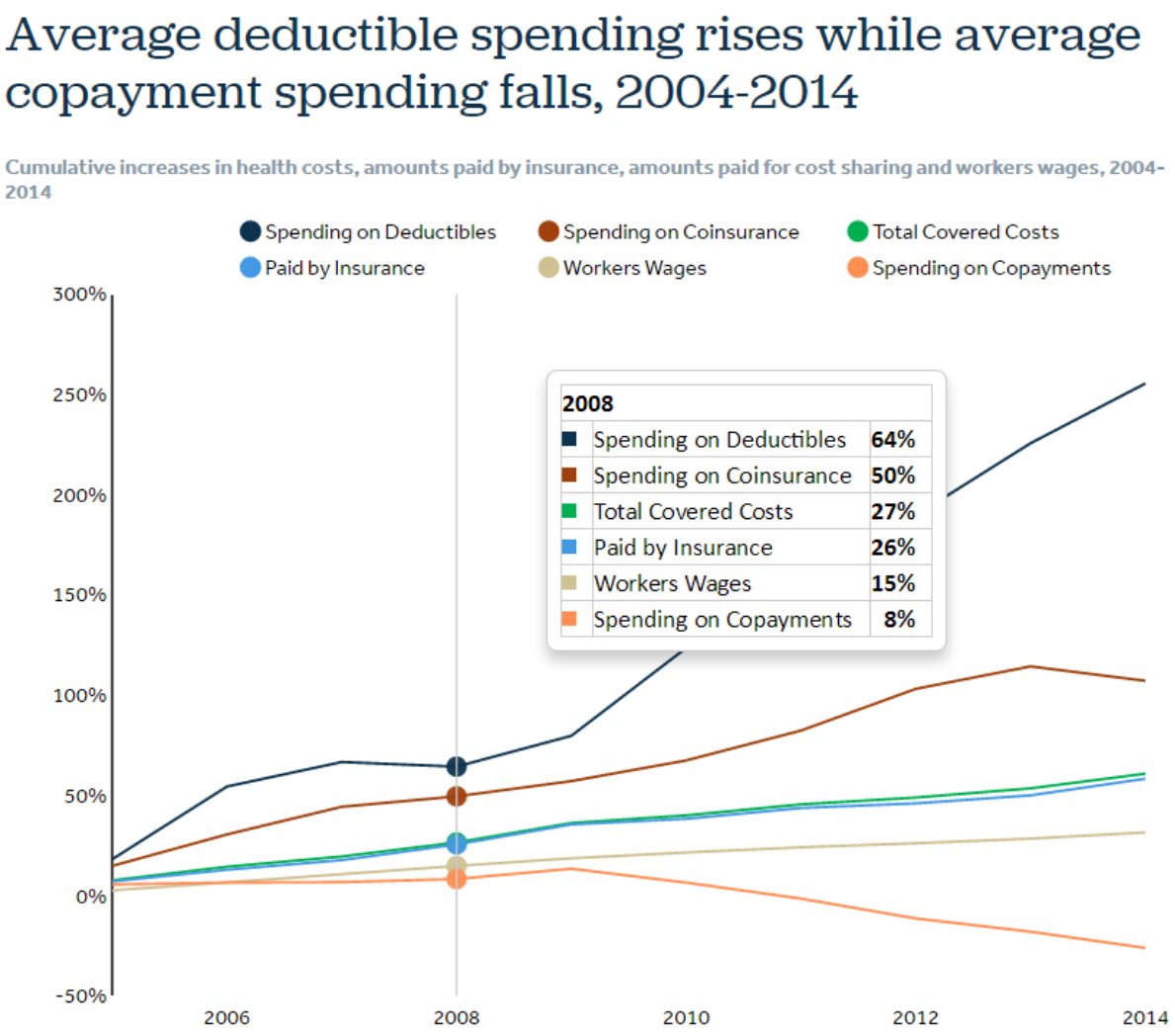


Source: Calculated from premiums reported in the Kaiser Family Foundation Employer Benefits Survey and wages and salaries per FTE employee (BEA National Income and Product Accounts).

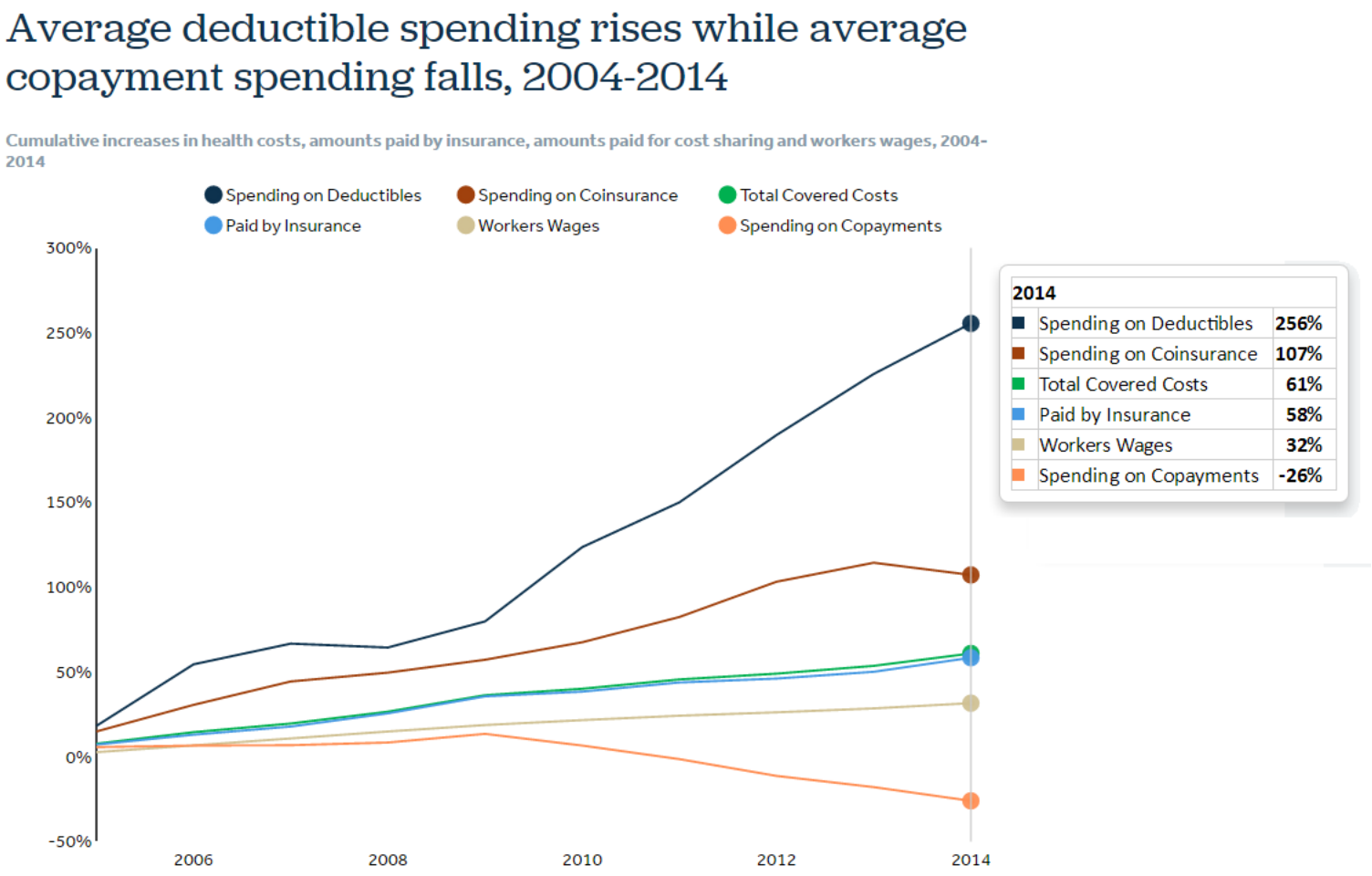
Appendix G


Average Family Premium as a Percentage of Median Family Income, 1999–2020
25%
20%
15%
10%
5%
0%
11%
12%
13%
14%
16%
17%
18%
18%
18%
18%
18%
19%
19%
19%
20%
20%
21%
21%
22%
22%
23%
24%
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Projected
Source: Commonwealth Fund calculations based on Kaiser/HRET, 1999–2008; 2008 MEPS-IC; U.S. Census Bureau, Current Population Survey; Congressional Budget Office.
THE COMMONWEALTH FUND

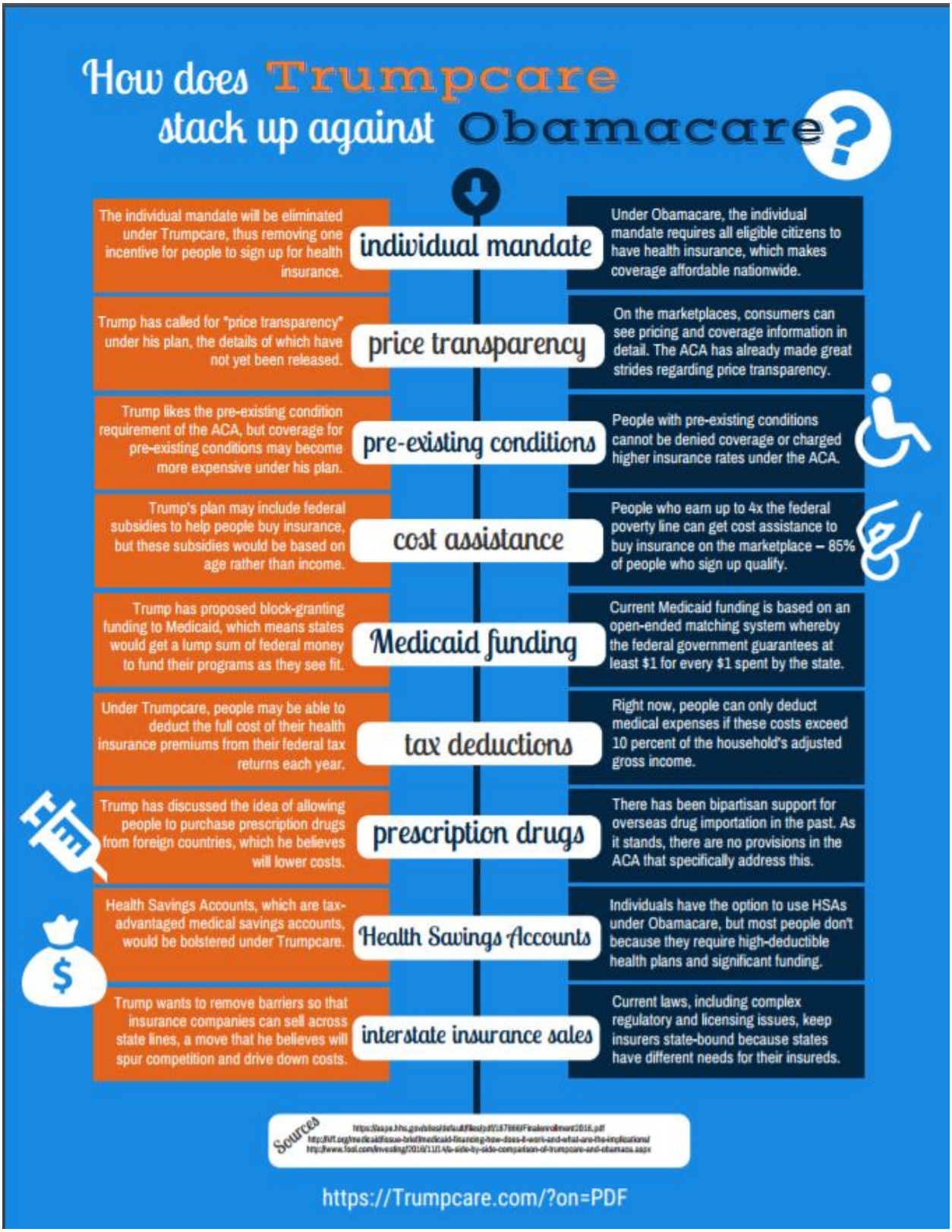
Appendix H


Average deductible spending rises while average copayment spending falls, 2004-2014
Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2004-2014
Spending on Deductibles
Spending on Coinsurance
Total Covered Costs
Paid by Insurance
Workers Wages
Spending on Copayments
300%
250%
200%
150%
100%
50%
0%
-50%
2006
2008
2010
2012
2014
2008
Spending on Deductibles 64%
Spending on Coinsurance 50%
Total Covered Costs 27%
Paid by Insurance 26%
Workers Wages 15%
Spending on Copayments 8%

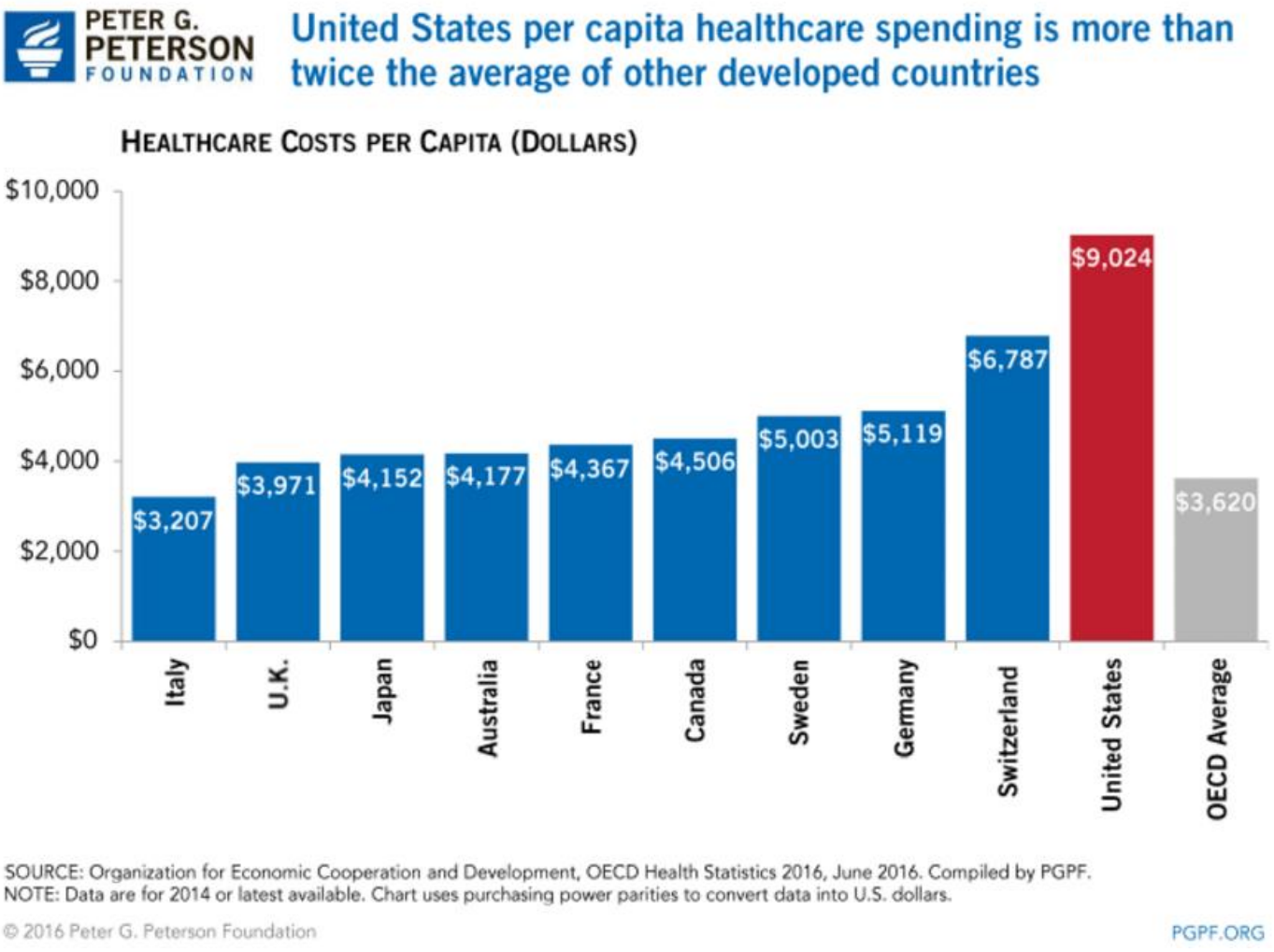
Appendix I


Average deductible spending rises while average copayment spending falls, 2004-2014
Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2004-2014
Spending on Deductibles
Spending on Coinsurance
Total Covered Costs
Paid by Insurance
Workers Wages
Spending on Copayments
300%
250%
200%
150%
100%
50%
0%
-50%
2006
2008
2010
2012
2014
2014
Spending on Deductibles 256%
Spending on Coinsurance 107%
Total Covered Costs 61%
Paid by Insurance 58%
Workers Wages 32%
Spending on Copayments -26%

Appendix J


How does Trumpcare stack up against Obamacare?
individual mandate
The individual mandate will be eliminated under Trumpcare, thus removing one incentive for people to sign up for health insurance.
Under Obamacare, the individual mandate requires all eligible citizens to have health insurance, which makes coverage affordable nationwide.
price transparency
Trump has called for "price transparency" under his plan, the details of which have not yet been released.
On the marketplaces, consumers can see pricing and coverage information in detail. The ACA has already made great strides regarding price transparency.
pre-existing conditions
Trump likes the pre-existing condition requirement of the ACA, but coverage for pre-existing conditions may become more expensive under his plan.
People with pre-existing conditions cannot be denied coverage or charged higher insurance rates under the ACA.
cost assistance
Trump's plan may include federal subsidies to help people buy insurance, but these subsidies would be based on age rather than income.
People who earn up to 4x the federal poverty line can get cost assistance to buy insurance on the marketplace – 85% of people who sign up qualify.
Medicaid funding
Trump has proposed block-granting funding to Medicaid, which means states would get a lump sum of federal money to fund their programs as they see fit.
Current Medicaid funding is based on an open-ended matching system whereby the federal government guarantees at least $1 for every $1 spent by the state.
tax deductions
Under Trumpcare, people may be able to deduct the full cost of their health insurance premiums from their federal tax returns each year.
Right now, people can only deduct medical expenses if these costs exceed 10 percent of the household's adjusted gross income.
prescription drugs
Trump has discussed the idea of allowing people to purchase prescription drugs from foreign countries, which he believes will lower costs.
There has been bipartisan support for overseas drug importation in the past. As it stands, there are no provisions in the ACA that specifically address this.
Health Savings Accounts
Health Savings Accounts, which are tax-advantaged medical savings accounts, would be bolstered under Trumpcare.
Individuals have the option to use HSAs under Obamacare, but most people don't because they require high-deductible health plans and significant funding.
interstate insurance sales
Trump wants to remove barriers so that insurance companies can sell across state lines, a move that he believes will spur competition and drive down costs.
Current laws, including complex regulatory and licensing issues, keep insurers state-bound because states have different needs for their insureds.
Sources
https://Trumpcare.com/?on=PDF

Appendix J


PETER G. PETERSON FOUNDATION
United States per capita healthcare spending is more than twice the average of other developed countries
HEALTHCARE COSTS PER CAPITA (DOLLARS)
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$3,207
$3,971
$4,152
$4,177
$4,367
$4,506
$5,003
$5,119
$6,787
$9,024
$3,620
Italy
U.K.
Japan
Australia
France
Canada
Sweden
Germany
Switzerland
United States
OECD Average
SOURCE: Organization for Economic Cooperation and Development, OECD Health Statistics 2016, June 2016. Compiled by PGPF.
NOTE: Data are for 2014 or latest available. Chart uses purchasing power parities to convert data into U.S. dollars.
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