ALTARUM
HEALTHCARE VALUE HUB

BLOG POST | MARCH 2020

10 Years Since The ACA: Policy Now Rooted in the Strongest Evidence Base Ever

BY LYNN QUINCY, DIRECTOR OF THE HEALTHCARE VALUE HUB

The Patient Protection and Affordable Care Act (ACA) was undoubtedly one of the most important pieces of U.S. domestic legislation in the last 50 years. On this 10-year anniversary, myriad retrospectives on the ACA will surely point out both its flaws and its shining successes. Both proponents and detractors must acknowledge, however, that the ACA has fundamentally changed the larger paradigm in which we debate policy. Today, the discussion is "how" we will cover everybody in an affordable manner and without penalizing those with pre-existing conditions, not "if." Where decades of earlier state and federal efforts failed, the ACA made significant progress in addressing high rates of uninsurance and included other valuable innovations.[1]

In honor of the anniversary, we use our platform to highlight another significant attribute of the past decade. For reasons related to the ACA, but also for unrelated reasons, we are operating with significantly more evidence about the policies that work and don't work to improve access to coverage; improve the quality of coverage; and address the underlying health system issues that lead to pricing outliers, care coordination failures, and inefficient care delivery.

Here are our top five policy knowledge gains:

1. ***High deductible health plans don't drive value in the marketplace***

   High deductibles were the key strategy for slowing the rise in health insurance premiums for many years. Proponents of this strategy claim that "skin in the game" will incentivize consumers to be careful shoppers, place pressure on low quality/high price providers, and improve marketplace functioning. A host of studies from the last 10 years have shown that this is not the case at all.[2] Consumers in these plans curtail both necessary and unnecessary services (worsening health outcomes, particularly for lower-income families), as they do not price shop or compare providers based on quality. Moreover, in selected instances where patients tried to compare providers, they found it almost impossible to do so. Employers[3] and others are starting to realize that high deductible health plans should be replaced with smarter, evidence-based cost-sharing designs and a downstream approach to addressing the root of high healthcare costs by reducing low-and no-value care,[4] curbing excess healthcare prices, and ensuring that high-value care is delivered at the right levels.[5]

2. ***Price transparency has a role to play but not the role originally envisioned***

   At both the state and federal levels, numerous efforts have been made to expose healthcare prices. Early efforts focused on displaying "list charges" and later efforts focused on the negotiated rates that are actually paid. Early thinking was that patients would use this information to, again, drive value in the marketplace by shopping. We've learned since that most healthcare

is not "shoppable"[6] and patients have little autonomy beyond the point at which they initiate treatment. From that point forward, the provider typically decides the services that are needed and where referrals will be made. Put simply, the complexity of weighing treatment options — with unknown prices and difficult-to-predict outcomes – means that patients rely heavily on the recommendations of their physicians.[7]

While the prior 10 years failed to find evidence that consumer-facing price transparency will help healthcare markets work better, emerging evidence suggests that price transparency targeted to other audiences can support sound policy and regulatory decisions, as well as help level the playing field in negotiations between providers, health insurance carriers, and payers. On the other hand, our efforts to put actionable ***quality*** information in front of consumers are nascent and we don't yet know the effects that such transparency might have on the market.

3. ***An individual mandate may not be needed to get people enrolled, especially if other enrollment inducements are present***

The ACA originally included a tax penalty for individuals who did not enroll in coverage when an affordable option was available to them. This penalty was in effect from 2014 (when the marketplaces opened) until 2019, when the Trump administration eliminated penalties for non-compliance. Originally, policymakers believed that this mandate was essential to overcoming the risk that healthy people would not participate in the market, driving up costs for less healthy people who enrolled. What we observed in 2019 was that healthy enrollees stayed in the market and there has been no market death spiral. This natural experiment created by the elimination of penalties, along with a much better understanding of how consumers make insurance purchasing decisions,[8] has revised our earlier understanding.

To be sure, coverage mandates (such as those states are establishing now) have a useful role to play. A rigorous study examining the 2019 policy change concluded that the mandate meaningfully increased insurance coverage, although by less than was projected when the ACA was implemented.[9] Moreover, state efforts have shown that coverage mandates can take different forms. Instead of imposing a penalty, Maryland's state healthcare exchange will use information reported on tax returns to determine if the taxpayer qualifies for coverage.[10] It will be interesting to see how Marylanders respond.

4. ***Medicaid works!***

The role of Medicaid in the ACA's coverage expansion and the resulting state-level controversy over whether or not to expand Medicaid under ACA guidelines has prompted a host of research studying the effects of Medicaid expansion. Overwhelmingly, these studies have found that Medicaid expansion reduces uninsured rates, improves access to care, utilization of services, healthcare affordability, and financial security among the low-income population.[11] Medicaid expansions also reduce uncompensated care costs for hospitals and clinics.[12]

Multiple studies suggest that expansion can achieve savings by offsetting states' costs in other areas. As a recent study examining Michigan concluded that "Medicaid expansion … yields clear fiscal benefits for the state, in the form of savings on other non-Medicaid health programs and

increases in revenue from provider taxes and broad-based sales and income taxes through at least 2021. These benefits exceed the state's costs in every year."[13] Medicaid also enjoys popular support,[14] thus it is baffling why some states have not expanded Medicaid to cover all very low-income residents.[15]

5. ***Across party-lines, regular voters support government action on healthcare***

   The divisive political rhetoric since the ACA was originally debated suggests that, as a nation, we are deeply divided. Yet focus groups and polling from myriad sources[16] reveal that there is common ground among U.S. residents when it comes to healthcare concerns and a desire for change. Across party lines, people are extremely worried about being able to afford care when they need it. Additionally, they don't believe their personal actions, nor the unfettered market, can solve these problems. On both sides of the political aisle, people feel that their elected officials and regulators should take action to make healthcare more affordable.

Despite this tremendous knowledge-gain, there is still more we need to figure out. For example, we have yet to determine when provider payment reform moves the needle (and when it doesn't) and how to measure quality in a way that is meaningful for consumers. Nevertheless, there is no question that we are operating with much better evidence to guide policymaking compared to 10 years ago.

In what areas do you feel we have achieved major gains in our evidence to support policymaking?

And Happy Birthday, ACA!

Notes

1. Bhatnagar, Sabah, *More Than a Coverage Law, the ACA is Integral to Creating a High-Value Healthcare System*, Altarum's Healthcare Value Hub, Washington, D.C. (March 2020). https://www.healthcarevaluehub.org/advocate-resources/publications/more-coverage-law-aca-integral-creating-high-value-healthcare-system

2. Altarum's Healthcare Value Hub, *Improving Value: High Deductible Health Plans Don't Work*, Washington, D.C. (Accessed March 9, 2020). https://www.healthcarevaluehub.org/improving-value/browse-strategy/high-deductible-health-planshealth-savings-accounts-hsas

3. Andrews, Michelle, "Employers are Scaling Back Their Dependence on High Deductible Health Plans," *Kaiser Health News* (Oct. 29, 2019). https://khn.org/news/employers-are-scaling-back-their-dependence-on-high-deductible-health-plans/

4. Beaudin-Seiler, Beth, et al., *Estimating State-Level Prevalence of Low-Value Care Services Among the Privately Insured, 2015*, Research Consortium for ealth Care Value Assessment, Ann Arbor, MI. (January 2020). https://www.hcvalueassessment.org/application/files/5615/8050/0804/Research_Consortium_Research_Brief_No._2.pdf

5. Altarum's Healthcare Value Hub, *Improving Value: High Deductible Health Plans Don't Work*, Washington, D.C. (Accessed March 9, 2020). https://www.healthcarevaluehub.org/improving-value/browse-strategy/high-deductible-health-planshealth-savings-accounts-hsas

6. Quincy, Lynn, *Rethinking Consumerism in Healthcare Benefit Design*, Altarum's Healthcare Value Hub, Washington, D.C. (April 2016). https://www.healthcarevaluehub.org/application/files/8115/6241/7308/Hub-Altarum_RB_11_-_Rethinking_Consumerism.pdf

7. Chernew, Matthew, et al., *Are Healthcare Services Shoppable? Evidence From The Consumption of Low-Limb MRI Scane*, National Bureau of Economic Research, Cambridge, MA. (January 2019). https://www.nber.org/papers/w24869.pdf

8. Altarum's Healthcare Value Hub, *Consumer-Centric Healthcare: Choosing a Health Plan*, Washington, D.C. (2017). https://www.healthcarevaluehub.org/advocate-resources/publications/consumer-centric-healthcare-choosing-health-plan

9. Fiedler, Matthew, "The ACA's Individual Mandate In Retrospect: What Did It Do, And Where Do We Go From Here?", *Health Affairs*, Vol. 39, No. 3 (March 2020). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01433?journalCode=hlthaff

10. The Maryland measure initially included a provision that would have revived the individual mandate in Maryland, but with an innovative twist: the uninsured would have had a choice of paying a tax penalty or make a down payment on health insurance. That provision was taken out of the bill. https://wtop.com/maryland/2019/05/maryland-bill-aims-to-help-enroll-uninsured-in-health-plans/

11. Antonisse, Larissa, et al., *The Effects of Medicaid Expansion Under the ACA: Updated Findings From Literature Review*, Kaiser Family Foundation, Washington, D.C. (August 2019). https://wtop.com/maryland/2019/05/maryland-bill-aims-to-help-enroll-uninsured-in-health-plans/

12. Ibid.

13 Levy, Helen, et al., "Macroeconomic Feedback Effects of Medicaid Expansion: Evidence From Michigan," *Journal of Health Politics, Policy and Law*, Vol. 45, No. 1 (February 2020). https://read.dukeupress.edu/jhppl/article/45/1/5/140654/Macroeconomic-Feedback-Effects-of-Medicaid

14. Kaiser Family Foundation, *Data Note: 5 Charts About Public Opinion On Medicaid*, Washington, D.C. (2020). https://www.kff.org/medicaid/poll-finding/data-note-5-charts-about-public-opinion-on-medicaid/

15. HealthInsurance.org, *A State-By-State Guide to Medicaid Expansion, Eligibility, Enrollment, and Benefits*, (Accessed March 9, 2020). https://www.healthinsurance.org/medicaid/

16. See for example: https://www.publicagenda.org/reports/taking-the-pulse-where-americans-agree-on-improving-health-care/ and the Healthcare Value Hub's state level polls: https://www.healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey

ALTARUM
HEALTHCARE VALUE HUB

ABOUT ALTARUM'S HEALTHCARE VALUE HUB

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

Contact the Hub: 2000 M Street, NW, Suite 400, Washington, DC 20036
(202) 828-5100 | www.HealthcareValueHub.org | @HealthValueHub

Support provided by the Robert Wood Johnson Foundation