ACA and the Health Insurance Market

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Uninsured Prior to ACA

Prior to the Affordable Care Act, approximately 16%-17% of the nonelderly population in the U.S. lacked insurance.
- In Florida, about 25% lacked health insurance prior to ACA, second worse behind Texas

The health insurance system in the U.S. is largely employer-based, with private health insurance plans providing coverage for most working age adults
- Public plans include Medicare for disabled and 65+, Medicaid for low income disabled, children, and pregnant mothers, Veterans Administration

The way the health insurance system was set up, it left about 45 million Americans without health insurance coverage
Consequences of Being Uninsured

Diminished access to medical care
  ◦ When care is needed, it is usually obtained through emergency departments

Higher rates of morbidity and mortality
  ◦ Having health insurance diminishes mortality rates by 25%-50%

Financial stress and medical bankruptcy
  ◦ It has been estimated that about a third of all bankruptcies in the U.S. were related to medical bills prior to the ACA ~600,000 per year.
Who Were Most Likely To Be Uninsured?

Individuals who could not get insurance through their employer
- Unemployed or employer does not offer health insurance

Poor people who do not qualify for Medicaid
- In FL – this is all adults without a dependent or adults with a dependent that make more than 29% of the Federal Poverty Level
- About half of people who are uninsured give cost as the reason

People who have to purchase insurance through the individual market with preexisting conditions

Young, healthy people who think they are invincible
How Does Insurance Work?

Primary mechanism is by pooling risk to reduce variance in cost
- One person has a 10% chance of a $1000 event
  - 10% chance of costing $1000 and 90% chance of costing $0
  - Expected cost = \(0.10 \times 1000 = 100\)
- If two people who both have a 10% chance of a $1000 event pool their money
  - Four potential outcomes: (1) neither experience the event; (2) first person experiences event but second person doesn’t; (3) first person doesn’t experience event but second person does; (4) both people experience the event.
  - 90% x 90% chance neither experiences the event = 81% chance of costing $0
  - \((90\% \times 10\%) \times 2\) chance of one person experiencing the event = 18% chance of costing $1000 which would be $500 per person
  - 10% x 10% chance both experience the event = 1% chance of costing $2000 which would be $1000 per person
  - Expected cost is still $100 \((0.81 \times 0 + 0.18 \times 500 + 0.01 \times 1000)\)
  - Much lower risk of worse outcome and lower variance in potential cost
Private Insurance Industry

Primary goal of insurance companies is to make a profit
- Maximize premiums while minimizing payment for health care
- Do this by reducing exposure to risk
  - Maximize the size of the pool
  - Keep sick people out of the pool (preexisting conditions)
  - Get healthy people into the pool (young people)

Employer sponsored plans typically have a good risk profile as there are many people in the risk pool to lower variance in potential payouts and working people are typically healthier then non-working people

People without employer sponsored insurance have to purchase on the individual market where their risk is not pooled
- Would not sell insurance policies to people who are sick or have chronic conditions
- Must charge high premiums to reduce likelihood of paying more for health care than the premium
Insurance Market Failures

Societal goal of universal coverage was not being met through the health insurance market

- Market resulted in prices that were too high for many to afford, particularly for those who relied on the individual insurance market
  - Fewer and fewer employers were offering health insurance coverage
  - Healthy young people were not joining the risk pools to lower expected costs
  - Medicaid eligibility stopped at income levels that were so low that people were too rich for Medicaid but too poor to purchase insurance
  - People with preexisting conditions were excluded from the individual market as well as some employer sponsored plans
  - Coverage was structured to discourage expensive individuals from purchasing insurance
    - Limits on mental health and substance abuse care, exclusion of medications needed to treat expensive conditions
The Affordable Care Act (Obamacare)

The ACA was designed to keep the current insurance system in place but address several of the market failures to achieve universal insurance coverage

◦ Eliminated preexisting condition exclusions
◦ Enhanced risk pools to control expected costs with the new requirement to include expensive people with preexisting conditions in the pool
◦ Individual insurance mandate but can purchase through health insurance exchanges that pool individuals with premium subsidies based on income
◦ Allowing adults up to age 26 to remain on parents’ family insurance plan
◦ Require large employers (50+ employees) to provide health insurance
Affordable Care Act (continued)

Expanded Medicaid coverage to all adults at or below 138% of the Federal Poverty Level
  ◦ Supreme Court ruled that requiring Medicaid expansion was unconstitutional but held the rest of the provisions of the ACA in place
  ◦ 14 states have chosen not to expand Medicaid and are currently not considering expansion
  ◦ 3 states are currently considering expansion

Required health insurance companies to have Medical Loss Ratios of at least 85% for large groups and 80% for individual and small groups
  ◦ Could not spend more than 15%-20% of the premium dollars collected on administration, marketing, and profits (helps control premiums)
  ◦ Established the Transition Reinsurance Program to subsidize health plans that experience losses on the individual and small group market to ensure their participation on the health insurance exchanges
Recent Changes to ACA

• Tax Cuts and Jobs Act of 2017 removes the individual mandate
  • Fewer healthy people will sign up for insurance, increasing health care costs in the individual market

• HHS finalizes new rules that change ACA provisions
  • Allows short term health plans with lower benefit standards and newly defined non-essential benefits will not count toward annual and lifetime out of pocket caps
  • Risk adjustment transfers from plans with healthier enrollees to plans with sicker enrollees can be reduced by 50% reducing the incentive of health plans to enroll people with pre-existing conditions
  • Allows states to implement a work requirement for individuals qualifying for Medicaid through Medicaid expansion and charge premiums and co-payments
  • Allows health plans to automatically claim quality improvement expenses that can count toward towards the medical loss ratio, even if there are no such expenses
The uninsured rate is on the rise

QB 2013
18%

QB 2016
10.9%

QB 2017
12.2%

Source: Gallup-Sharecare Well-Being Index