Affordable Care Act (ACA) – Still No Data
Jim Felsen, February 2015, Great Cacapon, WV

Jonathan Gruber's apology to the American people for arrogantly, deliberately and gleefully misleading them about the benefits and costs of the Affordable Care Act (ACA)/Obamacare led to coining of a new word, "gruberization". Fortified by "gruberization" revelations, one political faction has vowed to correct or repeal the resulting ACA deficiencies, while the other has feigned ignorance of Gruber's role in the formation of the ACA – claiming it is a smashing success. I shrug, since we have no worthwhile evaluation data to know whether - from a "health" perspective - there are meaningful successes to celebrate or deficiencies to correct.

A few success/ failure selective "proofs" offered include: the number of newly insured, reduction in the percentage of uninsured, quality, access, and efficiency gains, slowdown in the rate of increase of health care spending, reduced access, reduced quality and continuity (including loss of personal physicians and hospitals), inability to obtain timely specialty appointments and increased insurance premiums, deductibles and cost sharing. Analyzed independently, such data are largely worthless to determine health system success or failure.

In elementary school many of us carried a brown bag lunch to school. As we entered high school our moms noted many of the lunches came home uneaten or were thrown in the trash. We pleaded that we tired of the same old items and it was not "cool" to carry a lunch. To assure us better nutrition, our moms agreed to provide each of us a quarter each day to buy a USDA nutritious meal at the school cafeteria. How much nutritional value did our mothers receive per quarter spent? Probably, little. In my case the quarter bought a five cents bag of Planters peanuts and orange soda, plus a fifteen cent game of Boston, at the local pool hall.

How much has health system value increased under Obamacare? The only way to validly determine this is to simultaneously track overall - and by sample cohorts of the American public - three "interdependent" indicators before and after ACA implementation. These "population" indicators are:

- health status,
- total direct and indirect health care spending and costs and,
- percentage of the population receiving appropriate, timely and quality care (especially primary and preventive). Improvements and innovations from medical research, as well as environmental/public health services, would fall under this indicator.

Health Status

Regarding health status, most (chronic) disease indicators will take at least a decade or more to show significant changes. Some acute changes, such as reduced drug overdose deaths, suicides and obesity could have a more rapid turnaround; no significant gains to date are recorded. In fact, United Health Foundations' 2014 *America's Health Ratings* show a setback from 2013 for obesity and inactivity ratings.

Percentage of the population receiving appropriate timely and quality care

Are more individuals receiving timely, appropriate and higher quality care, especially preventive services, that should eventually lead to better health status? On 10/29, *NPR* reported that a "JAMA Pediatrics" article showed a 3% increase in the use of preventive services by young adults newly covered by their parent's insurance between 2009 and 2011. *Roll Call* and *Congressionally Quarterly* on 9/25 reported increased health care spending and use of mental health and emergency services in this demographic segment.

According to the *AP (1/15)*," The Commonwealth Fund's biennial health insurance survey found that the proportion of US adults who skipped or delayed medical care because of cost fell from 43 percent in 2012 to 36 percent last year. The share of people who received treatment but had trouble paying their bills also dropped, from 41 percent in 2012 to 35 percent last year. *Kaiser Health News* (1/22) states a"10-state study, 'published in the New England Journal of Medicine', found the availability of primary care appointments for Medicaid patients rose by nearly 8 percentage points after the raise was enacted, compared to only about a 1 percentage point increase among privately insured patients." (It should be noted that primary care physicians received a limited "two year", substantial raise in Medicaid reimbursements that ended on 12/31/2014)

On the other hand, *USA Today* (1/1) reported that while low-income patients getting Medicaid through Obamacare are receiving care, high out-of-pocket costs are prompting many middle-class Americans to "skip doctor visits, put off medical procedures, avoid filling prescriptions and ration pills — much as the uninsured have done." A recent survey by the Commonwealth Fund found that four in 10 working-age adults put off medical care because of the cost. On 10/28, *US News and World Report* discussed a Health Care Cost Institute study that found 2013 health care spending per enrollee increased $183 from 2012 despite enrollees using fewer medical services. The exception was 19-25 year old women whose costs were steady because of receipt of "free" contraceptive services. The *Los Angeles Times* and *New York Daily News* on 12/4 discussed a CDC report revealing only about one-third of Americans with depression received appropriate mental health care. On 11/26, *NBC* discussed a CDC report revealing only 30% with HIV are receiving appropriate care.

A decrease in utilization of services is good news if it represents a decline in unnecessary services or a reduced need for services because of improved service quality, efficiency and health status. It is bad news if it represents a decrease in the receipt of timely, appropriate, quality care because of increased financial or delivery access barriers post ACA implementation.

Private and government initiatives such as "Choosing Wisely", "medical homes", new payment models such as Accountable Care Organizations (ACOs), e-prescribing, EHR "meaningful use" – as well as numerous QI initiatives - are intended to reduce unnecessary care as well as increase the efficiency of the care process. Some successes have been reported, such as a 9/17 *Government Executive* article that notes CMS reported $372 million in Pioneer ACO and "shared saving payments" and projected rapid growth in such models.

We know little about changes in the relative quality and timeliness of services. A December 20, 2014 *Washington Post* editorial announced Obamacare deserves credit for a reduction in patient errors in hospitals and on 12/19 *The Hill* reported that for the first time the number of hospitals receiving higher

payments will outnumber those penalized for subpar treatment. However, a 12/6 *Modern Healthcare* article notes that experts claim there are not adequate studies to reach a cause - effect conclusion.

A 12/4 *Reuter's* article cites a "JAMA Internal Medicine" study that showed physician ratings by patients do not match clinical quality data. There have been numerous recent press reports noting how only a handful of physicians participating in HHS/CMS QI programs, such as PQRS, meaningful use, electronic prescribing, will receive improvement incentive payment with most being penalized and required to return 2-4 % of their Medicare payments. It should be mentioned that most hospital and practitioner QI and efficiency initiatives were well in place before ACA implementation, confounding the interpretation of any actual impact.

Has access to timely, "appropriate", quality care actually decreased? A 10/15 *Los Angeles Times* article reports that emergency department (ED) care in its vicinity was high for the newly insured in the first year and then dropped off, but notes ED use is a complicated matter with studies in other areas showing different results. Post Obamacare there is little evidence total ED visits have declined although the number of "uninsured" ED visits have dropped.

A 10/3 *Sacramento (CA) Business Journal* article on California Governor Brown's actions to address "narrow network" reduced access is an example of reported serious post-ACA problems throughout the Nation. The meteoric increase in commercial "store" clinic s and the increasing rate of rural hospital closures (See 11/13 *USA Today*) also suggests a problem with access to timely and appropriate preventive and primary care, despite a large increase in federal monetary investments to expand Community Health Centers (CHCS/FQHCS). *Modern Healthcare* noted (9/24) that most Medicaid beneficiaries are "generally happy" with their coverage but report difficulty obtaining certain services and on 12/8 that 74% of those with government subsidized care (Medicare/caid) are satisfied with health care costs compared to 58% with private coverage.

Total direct and indirect health care spending and costs

The key ACA strategy to increase the receipt of timely care centered on containing cost and removing financial deterrents to access. The annual increase (currently about 4%/year) in health care spending began decreasing before implementation of the ACA and continued afterwards. There is no agreement why. Some attributed it to a slow economy. From a health systems evaluation perspective, changes in spending have little significance unless related to what is – and what is not – being purchased for how much (costs).

In early December 2014, nearly every major newspaper and network weighed in on a 12/3 report from CMS claiming the various cost containment and other provisions of the ACA accounted "in part" for the reduced increase in spending. At the same time, CMS predicted that for the coming years spending will record a sharp increase because of an improving economy and an increase in services consumed by those newly covered by the ACA. Others saw it much differently.

A 12/3 *Wall Street Journal* article suggested the slowdown in spending in part can be attributed to the ACA associated increase in premiums and deductibles changing consumers' behavior whereby they delay or forego receipt of timely services because they cannot afford the out of pocket costs. A 10/28

Washington Times article discussed premium increases as high as 78% for men and 45% for women in certain groups, but noted in a 11/21 article the average was about 10% (similar to that reported by CMS and *Kaiser Health News*.) The *Chicago Tribune* (11/29) and *Modern Healthcare* (11/20) discussed that even for many ACA plans, deductible are over $5,000. *Modern* Healthcare in a 12/9 article reported that between 2003 – 2013 premiums for employer family health insurance rose 73% while wages increased 16%.

The Commonwealth Fund reports that in 2013 "…9.6% of an employee's household income was spent on premiums and deductibles, compared with 5.3% in 2003." Annual deductibles rose from 55 percent eight years ago to 80 percent today. Meanwhile, "the size of the average deductible more than doubled in eight years, from $584 to $1,217 for individual coverage."Thus, the *Wall Street Journal's* suggestion could have merit and would be bad news since it could result in receipt of less needed care and downstream, preventable declines in health status.

CMS's claims are also suspect for other reasons. Although certain employers were granted exemptions, and certain States declined to expand Medicaid, a great number of individuals received coverage in the initial ACA enrollment. If indeed, as claimed, such coverage provided timely, true access to "first time" consumers of health services – and previously covered individuals continued to receive timely, appropriate services -one would anticipate a significant increase in health spending. One must also consider the cost of ACA implementation expenditures and subsidies, such as those to CHCS/FQHCS and ACA insured individuals. On 9/24 *Bloomberg News* pegged the Healthcare.gov implementation cost alone as $2.1 billion and on 9/25, *The Hill* stated the administrative and promotional cost of ACA implementation to date was over $73 billion, about $2,500 per enrollee. So why was there little increase in total health spending?

It begs plausibility that gains in system efficiency and quality, as discussed above, could have offset the claimed, significant increases in "first time" health service consumer purchases and the ACA related government administrative, promotional and subsidy expenditures, resulting in a slower rate of spending increases. It is more likely increased premiums and cost sharing contributions were directed to cover such "non-value added", ACA implementation costs and most, especially "unsubsidized", consumers actually decreased their consumption of timely, appropriate health care services.

A 12/19 *New York Times* article discussed a 2014 poll they conducted with *CBS* that found a 10 point increase last year in the number of Americans who view the receipt of basic medical services as a hardship. A 9/4 *New York Times* article reports 2014 per capita Medicare spending down from the previous year and offers several possible explanations. On 11/20 *US News and World Report, Kaiser Health News* and *CNBC* all reported on an 11/19 Commonwealth Fund study that found seniors are struggling with poor health, access to quality care, coordination of care and high costs.

Most of the data reported above are accurate. Much of the analysis represents "gruberization", especially if spun independently rather than interdependently with other data. The American public deserve less "gruberization" and more checking the pool hall at lunch time.