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Facing an Uncertain Future, The Affordable Care Act Turns Seven

It is a moment of extreme political irony that the Affordable Care Act (ACA) is set to celebrate its seventh birthday on the same day House Republicans take a major vote aimed at repealing the landmark legislation. President Obama signed the ACA into law on March 23, 2010, and on March 23, 2017, the House is set to vote on the American Health Care Act (AHCA), a bill specifically designed to begin to dismantle Obamacare. With possible repeal nipping at its heels, this is an important time to take stock and reflect on the benefits that the ACA has brought to Americans, particularly to vulnerable populations such as those living with chronic illnesses and disabilities. Advocates can point to these benefits as part of efforts to combat repeal.

In light of this historic confluence of events, advocates should:

- 1. Take a moment to look back on and celebrate how the country's health care system has transformed dramatically since the ACA was passed. This is an important time to document the gains made under the ACA on coverage, affordability, and consumer protections in health care coverage.**
- 2. Continue to push back against proposals that threaten the ACA's significant achievements in access to care. Any new changes to the ACA must, at a minimum, cover as many individuals, keep health insurance affordable, and maintain the strong consumer protections enshrined in the ACA.**

Coverage Gains: The ACA Brought the Uninsured Rate to a Historic Low

Since the ACA was signed into law in 2010, the rate of Americans without health insurance has dropped significantly. In 2010, about 16% of the American population, around 48.6 million people, went without health insurance and were one unforeseen illness or accident away from facing huge medical bills and the prospect of bankruptcy. Post-ACA, the uninsured rate is at a historic low, with only about [8.9%](#) of Americans, around 28.4 million people, going without health insurance. This means that over [20 million](#) Americans have gained health insurance as a result of the ACA's reforms to expand access to care. These individuals now enjoy financial protection from catastrophic health events, and have access to primary care and free preventive services like annual check-ups; in 2015, over [137 million Americans](#) had private coverage of preventive services with no cost sharing. These historically low rates are likely to go back up dramatically if the ACA is repealed. The nonpartisan Congressional Budget Office (CBO) estimated that the AHCA would result in [24 million Americans](#) losing their health coverage and access to care by 2026.¹

¹ For an analysis of the CBO score, please see our previous Health Care in Motion [here](#).

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It is particularly important to note that these coverage gains significantly benefitted populations that have historically faced higher uninsured rates than the rest of Americans. For example, LGBT Americans, and Black, Latino, and Asian Americans all enjoyed significant coverage gains under the ACA. Specifically:

- Communities of color are disproportionately more likely to lack health insurance and have stable access to care, as people of color generally face more [access barriers](#) and use less care than whites. The ACA made significant gains in [reducing](#) this access to care disparity, and the coverage gains seen under the ACA have significantly helped these groups. The rate of uninsured individuals among Black nonelderly adults dropped from 19% in 2013 to 11% in 2015. Similarly, Hispanic adults also saw the rate of uninsured drop from 30% in 2013 to 21% in 2015, and Asian Americans adults saw the uninsured rate cut in half, from 14% to 7%. Among white nonelderly adults, the uninsured rate drop was less pronounced (12% to 7%).
- Studies have shown that Americans identifying as lesbian, gay, bisexual, or transgender are [more likely](#) to report being uninsured than non-LGBT Americans, due to the [challenges and barriers](#) these individuals often face to access necessary health services. However, due in part to the implementation of the ACA, between 2013 and 2015 the percentage of LGBT Americans reporting that they lacked insurance decreased from 21.7% to 11.1%, a coverage increase larger than the non-LGBT population. Further, during the first full year of implementation of the ACA's coverage expansion, LGBT Americans with incomes under 400% of the federal poverty level saw their uninsured rate [drop](#) from 34% to 26%.

Consumer Protections: The ACA Reformed the Private Insurance Market to Make it Accessible to Lower Income and Vulnerable Individuals

The ACA's holistic approach recognized that health insurance and access to care should be available to everyone, including both those with relatively few health needs as well as those whose health requires more extensive care. Some of the most significant achievements realized under the ACA were the sweeping changes to the private insurance market that protected consumers from insurance practices that oftentimes left vulnerable populations, such as those living with pre-existing conditions, behind. In particular, the ACA:

- [Banned pre-existing condition exclusions](#) and health status underwriting.² Prior to the ACA, insurers often either denied coverage to someone living with a pre-existing condition, or only offered coverage at exorbitantly high premiums. Insurers frequently used these practices as tools to prevent higher cost enrollees, such as those living with chronic illnesses and disabilities, from obtaining private insurance. The Department of Health and Human Services estimates that, between 2010 and 2014, when the ACA's reforms first took effect, the share of Americans with pre-existing conditions that went uninsured fell by [22%](#), representing 3.6 million people gaining coverage that they could not have purchased under pre-ACA insurance underwriting practices. This protection continues to be important, as approximately [27%](#) of American adults under age 65, or 52 million Americans, are currently living with conditions that would leave them uninsurable if they applied for coverage in the pre-ACA insurance market.
- Introduced the [Essential Health Benefits](#). Essential Health Benefits (EHB) are the minimum package of 10 categories of items and services that all individual and small group insurance plans are required to cover. These include a robust range of services and treatments that are critical for individuals living with significant health needs to stay healthy, including prescription drug benefits, preventive services with no cost sharing, and substance use and mental health treatments. This ensured that an insurance card meant access to comprehensive services. These benefits have been instrumental in

² Health status underwriting refers to the practice of charging higher premiums based on an individual's health status.

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addressing the opioid epidemic in America. A repeal of the ACA is estimated to cause about [2.8 million Americans](#) with substance use disorders, including 222,000 with an opioid disorder, to lose their coverage, undoing the progress made to promote substance use and mental health treatment.

- Banned the use of [annual and lifetime dollar limits](#). Before the ACA, insurers often set limits on coverage during a year or an enrollee's lifetime, above which the plan would no longer pay for covered services. For many individuals with significant health needs, such as those living with a chronic illness or a disability, this resulted in 'maxing out' on their coverage and getting cut off from care when they needed it most. The ACA prohibited this practice in both the individual and group insurance market. Before this reform was implemented, an estimated [105 million](#) people were subject to these limits. The ACA ensured that these individuals no longer had to worry about whether their plans would continue to pay for coverage if they needed regular, costly care.
- Prohibited [discrimination](#) in health care access and coverage. The ACA's nondiscrimination provision, Section 1557, protects consumers from discriminatory insurance practices on the basis of race, color, national origin, sex, age, or disability. Despite the promises of the ACA, many individuals, particularly those with chronic health conditions, still struggled to obtain affordable coverage. This was often due to discriminatory practices by insurers, such as placing all medications needed to treat a particular health condition on the highest cost sharing tiers, intentionally failing to cover medically necessary medications, and posting intentionally vague or misleading formulary information. The Department of Health and Human Services issued [final regulations](#) implementing Section 1557³, making it clear that individuals could directly file suit against this discrimination instead of having to wait for the government to pursue a case.

Affordability: The ACA Helped Low-Income Americans Purchase Coverage and Slowed Premium Growth

The ACA sought to help those with limited incomes afford the monthly cost of health insurance by providing financial assistance to purchase coverage. These subsidies, the advance premium tax credits, were tied to both an individual's income as well as the cost of premiums in an individual's state. This calculation was meant to ensure that individuals and families with low and moderate incomes never had to pay more than 6.8% of their household income towards premiums for a silver-level plan.⁴ Because they adjust to match changes in plan premiums, the premium tax credits also protected consumers from rate increases each year. At the start of 2016, roughly 9.3 million Americans received an average of [\\$291](#) each month to help pay the cost of premiums for health insurance. For health insurance plans beginning in 2017, 72% of [marketplace consumers](#) could select a plan for less than \$75 a month, and 77% could select a plan for less than \$100 a month.

These subsidies provide needed financial support for moderate- and low-income individuals, who otherwise may have been forced to choose between medical care and other expenses like food, housing, and childcare. This was especially important for those facing significant health expenses, such as those living with chronic conditions, as lower socioeconomic status is [associated](#) with higher rates of chronic illnesses and disabilities.

While many have decried the ACA as causing upward pressure on premiums, it is important to note that premiums were already on the rise, and this upward trajectory actually slowed after the ACA was fully implemented. An [analysis](#) of the second-lowest cost silver level plans in 2014 found that premiums were between 10% and 21% lower than average individual market premiums in 2013, a year before the ACA's marketplaces began operating. However, consumers actually received more robust coverage for this reduced cost, as silver-level plans covered roughly 17% [more](#) health expenses than individual

³ For more information on the final regulations, please see CHLPI's analysis [here](#).

⁴ The ACA required categorization of plans on the marketplace by metal levels, corresponding with certain levels of generosity. For example, a silver plan pays for an average of 70% of an enrollee's health care expenses.

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market plans before the ACA. This meant that Americans were getting more ‘bang for their buck,’ receiving more robust coverage for a lower price.

Additionally, for certain low-income consumers who enrolled in a silver plan, the ACA further decreased costs by reducing the amount the plan requires for out-of-pocket costs, like the copay charged for a visit to the doctor. At the start of 2016, roughly 6.3 million Americans received this benefit, cutting down on the amount they were required to pay for everyday medical expenses like copays for prescription drugs. The ACA also sought to address the prescription drug “donut hole” in Medicare.⁵ The ACA reduced the Medicare Part D copayments seniors were required to pay, resulting in \$20.8 billion in savings to approximately 10 million Medicare beneficiaries since 2010, an average of \$1,945 per person.

Medicaid Expansion: The ACA Opened Early Access to Treatment for Millions of Vulnerable Americans

The ACA’s Medicaid expansion brought desperately needed relief for many low-income individuals with substantial health needs. Prior to the ACA, in most states an enrollee had to be both low income and “categorically eligible” to qualify for Medicaid, such as by being disabled. This presented a cruel irony for many people with a chronic health condition, as these rules forced them to wait and become sick enough to be considered disabled to qualify. For example, an individual living with HIV often had to forego treatment until they became disabled by AIDS before they would qualify for Medicaid coverage, even though care and treatment could have prevented this deterioration.

Medicaid expansion modified these rules to determine eligibility based on income, providing coverage to individuals with incomes below 138% of the federal poverty level, and moving our health care system to a more prevention focused model. This addressed the perverse incentive for state Medicaid programs to withhold care only until a disease or condition progressed, and allowed for earlier, less costly interventions. For example, people living with HIV have historically faced significant barriers to insurance coverage. In 2012, 18% of people living with HIV receiving some type of care did not have insurance but many were prevented from enrolling in Medicaid because their infection had not developed into AIDS. The ACA reduced this gap, and in 2014 the number of people living with HIV who were uninsured dropped to [14%](#). This was largely due to the Medicaid expansion, as people living with HIV covered by Medicaid increased from 36% in 2012 to 42% in 2014.

While the Supreme Court made the expansion optional for states to implement, the 32 states, including DC, that chose to take advantage of this expansion saw significant returns in the health and productivity of their citizens. In states with Medicaid expansion, individuals living with disabilities are significantly more likely to be [employed](#) (38% versus 31% in non-expansion states) and significantly less likely to be unemployed because of disability. Since 2013, enrollment in Medicaid has grown, and has extended comprehensive care to [14 million](#) low-income Americans as of December 2015.

While advocates celebrate the achievements of the ACA, they should also be aware of the current threat to these achievements, as the AHCA has gained significant traction in the past week. On Monday night, House Republicans offered up several [amendments](#)⁶ to the AHCA designed to win votes from more conservative members of the chambers that initially voiced their opposition to the bill, including the Freedom Caucus’s position that it would formally [oppose](#) the bill. The proposed AHCA amendments introduce many changes to the Medicaid provisions that proponents of access to care should be concerned about, including:

⁵ The “donut hole” refers to the Medicare Part D coverage gap where beneficiaries are required to pay the full cost of their medications in addition to the standard premium.

⁶ For a discussion of the previous version of the AHCA, please see our prior Health Care in Motion [here](#).

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- Medicaid Work Requirements: The amendment would allow states to establish a work requirement for certain non-disabled Medicaid enrollees as a condition of coverage, modeled after the requirements in the Temporary Assistance for Needy Families program. This is particularly concerning for people living with [chronic and disabling conditions](#) who are not eligible based on a disability category, but may still be living with conditions that preclude them from attaining employment. A work requirement would likely bar those who need care the most from obtaining it, forcing them to seek costlier late-stage interventions like emergency room visits.
- Medicaid Expansion: The ACHA as introduced would eliminate the special financial support for Medicaid expansion by 2020. Under the ACA, the federal government covers 90% of the cost to state governments of the Medicaid expansion population. The amendment would push up the timeline for ending the Medicaid expansion from 2020 to the end of 2017. After 2017, states would no longer retain the ability to cover the new expansion population at this enhanced rate, and this percentage would be reduced to match the amount of support the federal government provides for the rest of Medicaid. This will force states to make difficult financial decisions about whether they can afford to continue covering the expansion population on a shorter timeline than previously proposed. States would likely need to pay a combined [\\$32 billion](#) in funds to continue covering the expansion population.
- Medicaid Block Grants: Under the AHCA as amended, states would be given the option to choose a block grant rather than a per capita cap for their traditional adult and children populations starting in FY2020. States would be locked into this choice for a ten-year period. The amount states would receive under the block grant would be based on the amount they would have received under a per capita cap in FY2020, but would only grow with general inflation and would not take into account increases in enrollment. This would almost certainly fall short of the expected growth in Medicaid spending, and would hamstring states' ability to respond to unforeseen increases in need that may result from a recession or natural disaster. Along with this fixed funding mechanism, states would be allowed to re-define the conditions for eligibility for these populations as well as the services provided to them, except for certain low-income pregnant women and children in poverty. This is particularly concerning for higher cost individuals, such as those living with chronic conditions. States choosing a block grant would face reduced federal funding for an already-strained program, but would also be given the authority to cut eligibility and services to make up for these budget concerns. As those living with chronic illnesses and disabilities account for about [half of Medicaid spending](#), states will likely look to these populations when deciding where to cut services and enrollment. While the changes to Medicaid have been touted as increased flexibility to better serve a state's enrollees, this flexibility will be useless without financial support to pursue innovation and will only translate into the flexibility to cut services and eligibility for those that need care the most.

The amendment also included a number of changes that many of the Republican members of Congress have called for, including speeding up the repeal of the ACA's taxes to 2017 instead of 2018 and delaying the ACA's Cadillac tax from 2025 to 2026. The amendment likewise provides a fund for additional tax subsidies to help those aged 50 to 64, a key Republican voting bloc, who would see their premiums rise the greatest under the original bill according to the CBO report.

The response to these amendments in the House has generally been receptive. The amendments were [requested](#) by President Trump after it became clear that the AHCA as originally introduced would not garner the support of far-right House Republicans, including the Freedom Caucus. After the amendments were introduced, Freedom Caucus Chairman Mark Meadows said that the amendments, along with considerable whipping from Republican leaders and President Trump, have successfully [persuaded](#) some of its members to vote in favor of the AHCA, and walked back earlier statements that the Caucus would formally oppose the bill. The amendments have also won over four Representatives that voiced

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opposition to the AHCA as introduced, including Robert Aderhold (R-Ala.), Thomas MacArthur (R-N.J.), Tom McClintock (R-Calif.), and Martha McSally (R-Ariz.). President Trump has thrown his weight behind the AHCA this week, telling members that if Republicans do not pass the bill, they will likely [lose their seats](#) in 2018.

However, resistance to the AHCA continues. While the Freedom Caucus will not take an official position, potentially making it easier for members to break away from the opposition to the AHCA, many members still say they will not vote in favor. At least [27 members](#) of the Caucus are leaning towards no, including Chairman Meadows. This is in addition to more moderate Republicans such as Reps. Leonard Lance (R-N.J.), Charlie Dent (R-Pa.), and Lou Barletta (R-Pa.) who have also signaled they intend to vote against the bill. This poses a problem for House leadership, as they can only afford to lose 22 votes to avoid defeat.

Outside advocacy organizations have added to the opposition. The Club for Growth has warned that House leadership still has not made sufficient changes to the bill, and [launched](#) an ad campaign urging members to vote against the AHCA. Similarly, Heritage Action, the advocacy branch of the Heritage Foundation, warned that the AHCA does not go far enough to repeal the ACA. Heritage Action indicated that it will [‘key vote’](#) the bill, meaning that members that vote in favor of the AHCA will be scored unfavorably by the organization.

The AHCA is expected to reach the floor of the House for a vote this Thursday, March 23, 2017. Senate majority leader Mitch McConnell (R-K.Y.) has [indicated](#) that if the AHCA passes in the House, the Senate will take up the bill the following week, despite the statements of other Senators, including Tom Cotton (R-Ark.) and Mike Lee (R-Utah), that the amendments did not affect their opposition to the bill. Moderate Senators such as Susan Collins (R-Maine) and Lisa Murkowski (R-Alaska) have also opposed the AHCA. More than a dozen Senators remain undecided.

While the AHCA has garnered significant support, the CBO scores and other analyses show that it does not measure up to the success of the ACA. Advocates should reach out to their Representatives ahead of the expected floor vote this Thursday and educate them about the backward steps the AHCA takes from the ACA in terms of coverage, cost, and access to care through robust consumer protections, particularly for vulnerable populations. Advocates should look for a [revised version of the CBO report](#) that will examine the proposed amendments, and carefully review it to understand the precise impact the AHCA as revised will have on access to care.

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