Commentary

The Affordable Care Act: How Can We Know Whether the Intended Consequences Are Occurring and the Unintended Ones Are Being Avoided?

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ABSTRACT

When the Affordable Care Act (ACA) was signed into law on March 23, 2010, policymakers intended that it would improve access to care by lowering the uninsured rate, improve health care quality, and lower costs. Now, 4 years later, researchers and policymakers need to ask whether those intentions have been realized or whether the ACA has produced unintended consequences that affect patient care. This article raises the importance of assessing what changes in patient access and clinical care have occurred, points out how challenging those assessments may be to conduct, and concludes with a call to action about how those challenges might be addressed. (*Clin Ther*. 2015;37:747–750) © 2015 Elsevier HS Journals, Inc. All rights reserved.

Key words: Affordable Care Act, quality of care, access.

INTRODUCTION

When the Affordable Care Act (ACA) was signed into law on March 23, 2010, policymakers intended that it would improve access to care by lowering the uninsured rate, improve health care quality, and lower costs. Now, 4 years later, researchers and policymakers need to ask whether those intentions have been realized, or whether the ACA has produced unintended consequences that affect patient care. This article raises the importance of assessing what changes in patient access and clinical care have occurred, points out how challenging those assessments may be to conduct, and concludes with a call to action about how those challenges might be addressed.

THE ACA

The ACA increases health care coverage by a combination of federal cost subsidies, prohibiting denial of coverage for persons with preexisting conditions, mandating that persons purchase insurance, and the availability of electronic health insurance exchanges (exchanges) to make the process accessible to all. By May 2014, the Urban Institute Health Policy Center estimated that 8 million persons signed up for health insurance through the new exchanges and another 4.8 million enrolled in Medicaid.[1] With ~45 million previously uninsured Americans, a reduction of 12 million seems an important step.

Despite these promising numbers, it is not known whether the goal of expanded access has actually been achieved. Of the 12 million enrollees, how many of them already had insurance and merely used the exchanges to move from one insurance plan to another? Complicating the assessment, some previously insured persons lost insurance because their policies no longer met the ACA insurance guidelines.[2] To determine whether the ACA substantially reduced the number of uninsured, researchers need to determine the *net* number of newly insured persons. This determination would incorporate both persons gaining insurance and persons losing it. A recent report in the *New England Journal of Medicine* suggests that the uninsured rate may have fallen by 5.2%.[3] These early estimates will likely evolve as penalties for not having insurance rise and as enrollees in 2014 need to re-enroll for 2015. That re-enrollment will likely be influenced by a person's

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experience in 2014 and what insurance did and did not provide for that person. Ongoing assessments of who has and does not have insurance will be needed.

However, access to coverage is more nuanced than merely quantifying the number of people with health insurance. Access can be improved or impaired on the basis of the lowering or raising of financial barriers to receiving care. Recent analyses by Avalere Health show that a single person enrolled in a Silver Plan (third of 4 categories that are based on insurance premium cost and breadth of offerings) faces an average annual deductible (before any benefits apply other than selected preventive care services) of $2550. For persons enrolled in Bronze plans, the average deductible is $5150.[4] By contrast, in 2014, enrollees in employer-sponsored insurance had deductibles that averaged $1217.[5] In most ACA plans, patients also need to pay a 40% coinsurance rate for drugs in tiers 3 and 4 (eg, non-preferred branded medications and higher cost specialty drugs). With certain medications costing hundreds to thousands of dollars each month, the amount paid by patients can be substantial. What access barriers do these high-deductible and high-coinsurance rates create? Patients will have some financial protection due to selected states' regulations that place ceilings on drug copayments and ACA total out-of-pocket maximums. Considering these various factors, will patients facing increasing costs to receive needed therapies abandon them? A large body of research shows that drug adherence falls with rising cost sharing.[6] Moreover, a recent study examined the formularies in 12 states on the federal exchanges and found evidence of adverse tiering. In 12 of 48 insurance plans, all of the nucleoside reverse-transcriptase inhibitors (a widely prescribed HIV therapy) were in tiers with coinsurance of at least 30%. The investigators conclude that the benefit design may cause sicker patients to be persuaded to leave those insurance plans.[7]

Research is needed to inform policymakers whether access to care has improved or worsened. Unfortunately, this research will be challenging to conduct. Today, most administrative or claims databases by a single insurance company or by a Medicaid plan have gaps. An ideal database would show the longitudinal care of patients before and after the insurance changes occurred, as patients transitioned from a pre-ACA insurance plan to one of the new ACA exchange plans or to Medicaid. Even more challenging, most databases cannot capture the care of those patients who previously lacked insurance and track them forward in time when they gained insurance. It is likely that no single insurance database will have all of the needed information. A potential research solution would use an "all payer" database. These databases combine administrative claims information from all insurers in a geographic area. States such as Vermont, Oregon, or Utah have developed all payer repositories, and these might enable the tracking of patients from one insurance environment to another.[8] Although not nationwide in scope, questions like those mentioned above could be regionally addressed.

The Medical Expenditure Panel Survey offers another potential solution.[9] The Medical Expenditure Panel Survey is a database from cross-sectional interviews of persons and households in the United States and collects information on demography, health conditions, health status, use of medical services, health insurance coverage, and charges and sources of payment. Although not longitudinal by household, it is conducted regularly, and cross-sectional observations may shed light on improving or worsening access to care. A more definitive approach to tracking individual patient care would entail the adoption of a universal patient identifier (ID). Patients may transition from one insurance plan to another or one provider group to another, but the ID would remain constant and would enable longitudinal assessment of treatment patterns. The concept, in principle, seems straightforward and was proposed as part of the Health Insurance Portability and Accountability Act of 1996. However, concerns about patient privacy subsequently sidetracked this national initiative.[10]

The ACA also created new provider reimbursement models, shifting payment from traditional fee-for-service (or payment based on volume) to various performance-based payment models (or reimbursement based on value). These latter models consist of a fixed payment to compensate providers for managing an episode of care with additional payments based on achieving quality-of-care benchmarks. These new reimbursement approaches (eg, Medicare Shared Savings Program) incent providers to consider their diagnostic and therapeutic decisions because they receive a specific amount of funds and share in the savings if the cost of care does not exceed that amount. The US Department of Health and Human Services just announced its intention to markedly