

How to Heal Obamacare

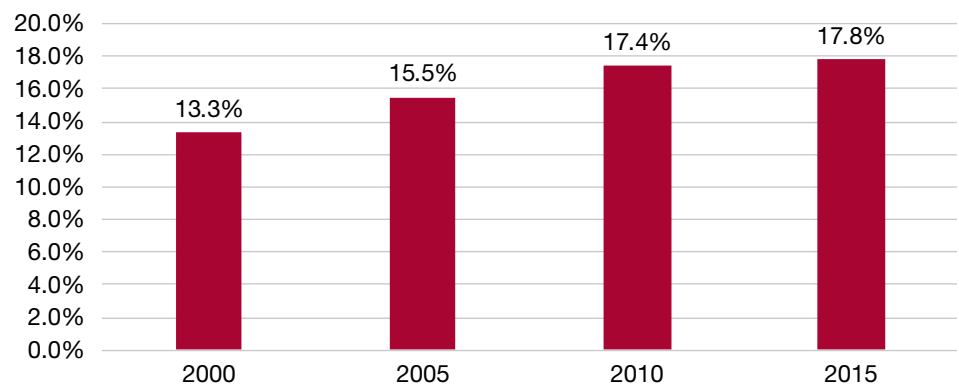
By Mark Duggan

Every argument for and against the Affordable Care Act came to a head this summer as opponents tried to repeal the 7-year-old law that is both loathed and lauded as Obamacare. And despite their failure during the summer, the political debate continues.

Supporters of the ACA come with their most compelling figures: The number of Americans without health insurance fell from 49 million in 2010 to 29 million in 2016 (HHS, 2017). The growth rate of health care spending slowed significantly after ACA passage. As shown in Figure 1, after rising from 13.3 percent to 17.4 percent during the 2000 to 2010 period, health care spending as a share of GDP rose to just 17.8 percent by 2015.

The law's detractors are armed with their strongest data, as well. They focus on rising prices in many of the state-based health insurance exchanges and a decline in the number of private insurers participating in the exchanges. The

Figure 1. Health Care Spending as a Share of US GDP



Source: Centers for Medicare and Medicaid Services, 2017

median premium increase from 2016 to 2017 was 19 percent. Additionally, 21 percent of exchange enrollees had just one insurer from which to choose in 2017. Just one year earlier, only 2 percent of enrollees faced such a lack of competition (Kaiser Family Foundation, 2017). These changes are consistent with earlier research that less competition in private health insurance markets leads to higher premiums (Dafny, Duggan, and Ramanarayanan, 2012).

At least one loud criticism of the law — that it was killing jobs — was discredited by research that I recently conducted with colleagues at Stanford (Duggan, Goda, and Jackson, 2017).

The ACA is far from a perfect piece of legislation. But it's now time for policymakers to dig into the law and find ways to make improvements — even as some critics are still looking for ways to scrap it.

In this policy brief, I describe in greater detail the impact of the ACA — focusing especially on provisions that were designed to expand health insurance coverage. I also discuss some potential reforms that could address some of the key shortcomings of the legislation — focusing mainly on stimulating competition and expanding choice in the health insurance exchanges.

About the Author



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Medicaid Expansion

The effect of the Affordable Care Act has varied substantially across the country. That’s largely because of states’ decisions about whether or not to expand Medicaid to residents with incomes below 138 percent of the federal poverty line (FPL) — or about \$34,000 for a family of four.

As of this month, only 31 states and the District of Columbia have expanded their programs.¹ Largely because of these changes, the number of Medicaid recipients in the U.S. increased from 58 million in late 2013 to 75 million this year.

The Medicaid expansions were fully funded by the U.S. government between 2014 and 2016, with the federal share of spending slowly declining to 90 percent by 2020. In expanding states, the fraction of residents enrolled in Medicaid increased from 19.2 percent in late 2013 to 26.6 percent by May 2017. The corresponding increase was much smaller in states that did not expand, with enrollment increasing from 16.3 percent to 18.3 percent during the same period.

Table 1 lists the 10 states with the largest increases in Medicaid enrollment from late 2013 until early 2017. Each state expanded its

¹ Some individuals with incomes below 138 percent of FPL are ineligible for Medicaid coverage. For example, undocumented immigrants or recent immigrants are typically not eligible.

Medicaid program and especially large enrollment increases were seen in New Mexico (a 16 percentage point gain); Kentucky (more than doubled with a 15 percentage point gain); and Arkansas (12 percentage points).

These three states have poverty rates significantly higher than the national average. States with similarly high poverty rates that did not expand Medicaid had much smaller increases in enrollment. For example, Alabama, Georgia, and Mississippi had increases of just 1 to 2 percentage points.

Table 1: Percent of State Residents Enrolled in Medicaid

State	Sept 2013	May 2017	Percent Change
New Mexico	22	38	16
Kentucky	14	29	15
Arkansas	19	31	12
West Virginia	20	31	11
California	20	31	11
Colorado	15	26	11
Rhode Island	18	29	11
Montana	15	25	10
Nevada	12	22	10
Washington	16	25	10

Source: CMS State Medicaid and CHIP Profiles

With full repeal of the ACA now looking unlikely, some states that chose not to expand their Medicaid programs may decide to reconsider.

The states that expanded Medicaid qualified for an additional \$70 billion in federal funding in 2015 (the most

recent year with complete data available). The 19 states that did not expand Medicaid received no similar incremental funding. This difference in federal funding is especially significant when one considers that state and local governments historically end up paying the medical bills for those without insurance, resulting in significant drains on their budgets (Hadley, 2008).

In essence, the 19 non-expanding states have decided to forgo a partial solution to that problem. And by not taking the extra federal payments for many of their low-income uninsured, these states have significantly lowered the federal budget deficit.

Insurance Exchanges

As of early 2017, there were 12.2 million U.S. residents receiving private insurance purchased through the state-based health insurance exchanges. This represents 4.5 percent of Americans below the age of 65, as hardly any seniors get their coverage through these exchanges.

Enrollees with incomes between 100 and 400 percent of FPL are eligible for subsidies through the exchanges.

As shown in Figure 2 for the median county in the U.S., these subsidies generally decline with income and rise with age. The majority (71 percent) of exchange enrollees receive subsidies for this coverage, with the average annual subsidy amounting to \$4,452. Total federal subsidies for

coverage purchased through the ACA exchanges were \$38.8 billion, which represents about 1.2 percent of total U.S. health care spending.

The fraction of each state's residents obtaining coverage through the exchanges varies even more dramatically than does the share on Medicaid.

The clear outlier among all states is Florida, with 10.8 percent of residents younger than 65 enrolled in the state's ACA exchange as of early 2017. Other states with especially high enrollment are Maine, Utah, Idaho, and North Carolina. Interestingly, none of these five states elected to expand their Medicaid programs.

Table 2 lists the 10 states with the highest fraction of their non-elderly populations enrolled in the ACA exchanges in 2017.

Table 2: Percent of Non-Elderly Residents Enrolled in ACA Exchanges in 2017

State	Percent Enrolled	Expanded Medicaid
Florida	10.8	No
Maine	7.4	No
Utah	7.4	No
Idaho	7.1	No
North Carolina	6.4	No
Montana	6.3	Yes
Vermont	6.0	Yes
Virginia	5.8	No
South Carolina	5.8	No
Georgia	5.6	No

Source: Kaiser Family Foundation Total Marketplace Enrollment

In contrast, the five states with the smallest share of their residents getting insurance through the exchanges — New York, Hawaii, Kentucky, West Virginia, and Minnesota — all did expand their Medicaid programs.²

This is consistent with the findings of recent research that private health insurance coverage increased by substantially more in the states that elected not to expand Medicaid (Duggan, Goda, and Jackson, 2017). It also implies that any changes in the generosity of ACA exchange subsidies for coverage purchased through the exchanges would differentially affect individuals in states like Florida, Utah, and North Carolina that did not expand their Medicaid programs.

Overall Coverage

An examination of data from Gallup (2017) sheds light on which states have experienced the largest increases in overall health insurance coverage since just before the implementation of the key features of the ACA almost four years ago. Interestingly, all 10 of the states with the largest reductions in the share of adults who were uninsured from 2013 to 2016, as shown in Table 3, expanded their Medicaid programs.

² Enrollment in these five states ranged from 1.5 to 2.4 percent of their non-elderly residents.

Table 3: Percent of Adult State Residents Uninsured in 2013 and 2016

State	2013	2016	Percent Change
Kentucky	20.4	7.8	-12.6
Arkansas	22.5	10.2	-12.3
West Virginia	17.6	6.1	-11.5
New Mexico	20.2	9.0	-11.2
California	21.6	10.5	-11.1
Oregon	19.4	9.1	-10.3
Washington	16.8	7.2	-9.6
Arizona	20.4	11.0	-9.4
Montana	20.7	11.3	-9.4
Louisiana	21.7	12.5	-9.2

Source: Gallup-Healthways Well-Being Index

Consistent with this, all 10 states with the highest fraction of adults who were uninsured as of 2016 elected not to expand their Medicaid programs.

As shown in Table 4, the state with the highest share is Texas, with 20.5 percent of the state's adult residents still without health insurance. Mississippi, Oklahoma, Georgia, and Florida round out the top five. As of 2016, the fraction of residents in expanding states who were uninsured was 8.2 percent (about 1 in 12), while the corresponding share in non-expanding states was almost 80 percent higher at 14.5 percent (about 1 in 7).

Table 4: Ten States with the Highest Percent Uninsured in 2016

State	Percent Adults Uninsured
Texas	20.5
Mississippi	17.2
Oklahoma	16.3
Georgia	15.6
Florida	14.6
Idaho	14.0
Alabama	13.6
North Carolina	13.6
South Carolina	13.1
Wyoming	12.9

Source: Gallup-Healthways Well-Being Index

Recent research indicates that the ACA-induced increases in health insurance coverage have increased economic well-being (Brevoort, Grodzicki, Hackmann, 2017; Gallagher, Gopalan, Grinstein-Weiss, 2017) and increased access to health care (Sommers et al, 2015). Greater coverage can also provide additional resources for health care providers that differentially treat those without health insurance while simultaneously easing the pressure on state and local budgets that are often responsible for the costs of uncompensated care to the uninsured.

Reductions in Competition

Premiums for health insurance purchased in the ACA exchanges increased much more rapidly in 2017

than in the two previous years. One key driver was the planned 2016 expiration of the ACA’s reinsurance payments to insurers. These payments are essentially “insurance for insurers” and were designed so that insurers would not have a strong incentive to avoid very high-cost patients (Hall, 2010).

Between 2014 and 2016, the federal government covered most of the costs for very high-cost patients who were enrolled in the exchanges through reinsurance.³ But the ACA included these payments for just the first three years to assist with the startup of the exchanges. Beginning in 2017, insurers no longer received these payments. This mechanical increase in insurers’ costs caused them to increase premiums by significantly more than they otherwise would have.

But the reduction in competition in the exchanges described above also contributed to the increase in premiums from 2016 to 2017.

Competition is now especially limited in markets with a relatively small population. For example and as shown in Table 5, among counties with populations of less than 25,000, the average number of insurers in 2017 was just 1.8 versus 2.9 in

³ In 2014, the federal government covered 80 percent of an individual’s costs above \$45,000 for the year. The next year this declined to 50 percent. And in 2016, reinsurance covered 50 percent of the costs above \$90,000 for the year. As a result, reinsurance funding fell from 2014 to 2016 and will be zero in 2017 and beyond (Cox et al, 2016).

counties with populations of 500,000 or more.⁴

Table 5: Average Number of ACA Private Insurers by County Population in 2015 and 2017

County Population	2015	2017
> 500k	5.8	2.9
250k - 499k	4.8	2.6
100 – 249k	4.4	2.4
50 – 99k	3.6	2.0
25 – 49k	3.4	1.9
< 25k	2.9	1.8

Source: Kaiser Family Foundation County-Level Data

This represents a significant reduction from just two years earlier with substantial reductions in competition in larger markets during that time as well. Perhaps most strikingly, nearly 40 percent of counties with fewer than 25,000 residents are currently served by just one private insurer.

Reforming the ACA: Six Ideas

Following are six considerations for policymakers focused on increasing competition and choice.

Expand choice in smaller markets:

One possible policy lever that could enhance competition in smaller markets would be to bundle these markets with larger urban areas. In other words, in order to serve the

⁴ For these statistics, I considered only the 39 states that use the healthcare.gov platform, thus excluding California, Kentucky, and 10 other states.

larger urban area, an insurer would have to also serve the smaller market.

Some states have taken this approach while others have allowed each county to be its own market. As three co-authors and I pointed out in recent research, rural counties that were bundled with nearby urban counties had more private insurers competing and lower premiums and thus better market outcomes (Dickstein et al, 2015). This would be a straightforward way to reduce the gap in competition between large and small markets.

Increase reimbursement in smaller markets: The limited interest of private insurers in smaller markets is not unique to the ACA exchanges. Similar problems existed for Medicare Advantage (MA), the program through which nearly one-third of Medicare recipients now obtain private health insurance coverage, during the 1980s and 1990s. Large counties tended to have many more options than smaller counties, and as a result virtually all rural residents were enrolled in traditional fee-for-service Medicare rather than MA. But in 1998, the federal government introduced floor payments in smaller low-cost markets that significantly increased insurer interest and led to a large increase in insurer entry (Duggan, Starc, and Vabson, 2016). Similar enhancements could be made to the reimbursement of ACA plans in smaller markets with little or no competition.

Add Medicaid Managed Care plans as an option: Another way to expand choice in the exchanges would be to allow enrollees to acquire coverage in private Medicaid managed care (MMC) plans. Currently, more than 2 in 3 Medicaid recipients are in a private MMC plan (Duggan and Hayford, 2013).

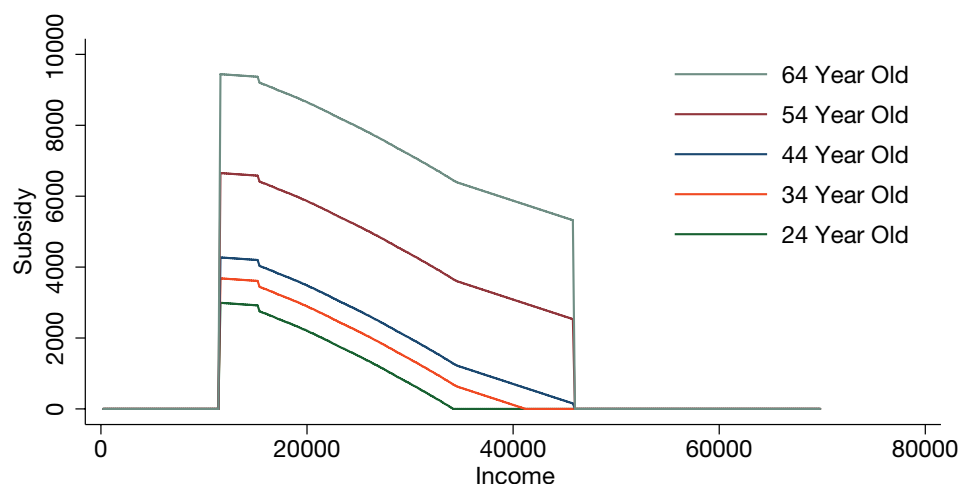
Many of today's Medicaid recipients will later enroll in the ACA exchanges as their income rises and will then return to Medicaid plans when their income declines. In counties with limited or no participation in the ACA exchanges, states and MMC plans could expand their coverage to include exchange enrollees. Given that all but three states (Alaska, Connecticut, and Wyoming) have a significant MMC presence, this could substantially expand choice and increase competition in many underserved markets.

Increase incentives for young adults to enroll: Americans between 25 and 34 were almost twice as likely as those between 45 and 64 to be uninsured prior to the ACA (28 percent versus 15 percent in 2009). Despite this, the ACA provides much lower subsidies to younger adults as shown in Figure 2.⁵

And for those young adults not receiving subsidies, age rating regulations likely increase their premiums above what they otherwise would be. More specifically, the ACA does not allow premiums for older recipients to be more than three times greater than for younger

⁵ This is because the ACA adjusts the subsidy so that individuals with, for example, income of 200 percent of FPL would pay just 4 percent of income on their health insurance plan. This would imply about \$1,000 for a single adult. But the cost of the plan is much higher for older enrollees so the subsidies are correspondingly higher too.

Figure 2. ACA Subsidies by Income and Age in the Average Market in 2015



Note: Subsidy calculated for single person in 2015 for all scenarios.

recipients despite their expected costs often being more than three times higher. These factors serve to reduce enrollment among young adults and increase premiums in the exchanges. Revisions to the age-rating regulations or to the subsidy formula that target young adults could lead to substantial increases in coverage at relatively low cost.

Fund outreach to the uninsured:

During the last four years, the federal government and individual state governments have spent a great deal of time and money on informing the public about the availability of health insurance coverage through Medicaid and the insurance exchanges.

That's led some who would otherwise be uninsured to enroll in Medicaid or to purchase subsidized coverage in their state exchange. At the federal level, funding for this outreach was scaled back considerably in early 2017.

This affects the 34 states with exchanges that are controlled entirely by the federal government. However, many of the other 17 states expanded outreach efforts last year. Previous research has shown that outreach can make a significant difference for enrollment in government programs (Aizer, 2003; Karaca-Mandic et al, 2017). Consistent with this, in the 34 states with federally run exchanges, enrollment fell by 4.4 percent from 2016 to 2017. In contrast, in the other 17 states where outreach efforts were generally expanded, enrollment rose by 2.1 percent (Curran et al, 2017).

This divergence in enrollment trends seems likely to continue in 2018, with federal funding for outreach efforts slated to fall by 90 percent (from \$100 million to \$10 million) in the current fiscal year. To the extent that states with federally run or state-administered exchanges want to hold constant or increase health insurance coverage among their residents in the months ahead, expanding state and local funding for outreach is likely to have a high payoff.

Reduce uncertainty about cost-sharing subsidies:

Americans with incomes between 100 and 400 percent of FPL qualify for subsidies to purchase private coverage through the ACA exchanges. The benchmark “silver” plan in the exchanges has an actuarial value (AV) of 70 percent, meaning that the insurer covers 70 percent of expected health care costs.

Plans with an AV in this range typically have relatively high deductibles and co-payment amounts. Individuals with incomes between 100 and 250 percent of the poverty line qualify for additional federal subsidies to reduce these out-of-pocket costs.

The cost-sharing subsidies help those with lower incomes cover the cost of deductibles and co-payments, which can amount to thousands of dollars following a major medical problem. These subsidies partially explain why lower income individuals are substantially more likely to enroll in the exchanges than their counterparts making more money.

For example, among individuals without another source of coverage and with incomes between 150 and 200 percent of the federal poverty line, 55 percent take up coverage in the exchanges. The corresponding take-up rate for those with incomes between 300 and 400 percent of the federal poverty line is just 14 percent (Buettgens, Kenney, and Pan, 2015).

In recent months, there has been uncertainty as to whether these cost-sharing subsidies would continue. The total amount spent on subsidies will amount to about \$7 billion in 2017, which is substantially lower than the \$38 billion for premium subsidies.

The Congressional Budget Office estimated that premiums in the ACA exchanges would increase by 20 percent if these subsidies were terminated (CBO, 2017). This would lead to large reductions in health insurance coverage as some individuals would be priced out of coverage. By continuing these cost-sharing subsidies, policymakers could prevent substantial price increases and insurer exits. A recent effort to forge a bipartisan compromise has focused primarily on this issue (Hackman, 2017).

Conclusion

While the six potential reforms outlined above will not address all of the limitations of our current health care system, they would lead to further increases in insurance

coverage and — through increases in competition — prevent large price increases in the ACA's health insurance exchanges. These reforms could lead to additional reductions in the number of uninsured and help keep the growth in overall health care spending low by historical standards.

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