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The Affordable Care Act: Five Years Later

Andrew Dana Izatt
Utah State University

THE AFFORDABLE CARE ACT: FIVE YEARS LATER

by

Andrew Dana Izatt

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Approved:

Thesis/Project Advisor Dr. Shannon Peterson	**Committee Member** Dr. Frank Caliendo
Departmental Honors Advisor Dr. Shannon Peterson	**Director of Honors Program** Dr. Kristine Miller

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The ACA: Five Years Later

Introduction

The challenges facing the American health care system are well known and manifold. The United States pays substantially more for its health care than any other developed, industrialized nation. Per capita health care spending in 2012 was $8,745,[1] up from $356 in 1970[2] without marked improvements in life expectancy, quality of life, or outcomes.[3] But despite all of our health spending, large portions of our population go without health insurance. Being uninsured carries real consequences. A report published in the American Journal of Public Health, by researchers at Harvard Medical School, using statistics from the Centers for Disease Control and Prevention, found that more than 45,000 people die every year because they cannot get access to health care — more than drunk driving and homicide combined.[4] Cost is the biggest reason why people go without health insurance.[5] The Patient Protection and Affordable Care Act (ACA—also known by both its proponents and detractors as Obamacare), was the most comprehensive health reform in nearly 50 years[6] seeking to address both the uninsured problem and out-of-control health spending. This paper will examine the ACA's success in decreasing the uninsured rate with an analysis of its accompanying impact on costs in the market most affected by the law[7]—the individual or non-group market.

ACA Background

Signed in March 2010, the ACA sought to expand health insurance coverage through a combination of Medicaid expansion and the creation of insurance

marketplaces, or exchanges, for the individual or non-group insurance market with subsidies available for low-income individuals and families. Among its other changes, it included 10 federally mandated coverage requirements. These include mental health and substance abuse services, prescription drugs, rehabilitative care and free preventative care such as immunizations and physicals. Insurers cannot deny coverage for pre-existing medical conditions, charge women more than men, nor charge their oldest enrollees more than three times that of their youngest. It placed annual limits on cost-sharing but prohibited limits on annual benefit payouts.[8] But perhaps its most controversial aspect was the individual mandate—that all Americans (with some specific exemptions) must have health insurance or face a penalty.[9] After several Supreme Court challenges (including one pending), dozens of attempts at repeal,[10] and a less-than-stellar rollout, the ACA and its exchanges are up and running for the second year in 2015.

While the ACA as a whole fares poorly among many Americans, the same polls reveal most individual ACA provisions enjoy strong support among the public.[11] Predictably, opinions fall along partisan lines. 74 percent of Republicans report an unfavorable view of the law with 65 percent of Democrats approving of it. More independent voters have an unfavorable opinion than a favorable one—47 percent to 37 percent respectively.[12] "People who favor the law appreciate its expansion of coverage and benefits, while those who don't like the ACA insist that it's because they perceive the health-care law as driving up insurance costs."[13] Remarkably, of those that report an unfavorable view of the ACA, a large majority of

them report neither knowing anything about it nor having been affected by it in any way.[14]

Impact on the Uninsured

Unlike costs and health care spending, as we will see, examining the success of the ACA in decreasing the uninsured rate is relatively straightforward. In 2013, nearly 42 million nonelderly Americans from 18-65 went without health insurance.[15] The latest Department of Health and Human Services (HHS) numbers show uninsured rates in the U.S. in 2015 have experienced their biggest drop in four decades.[16] After the latest enrollment period, nearly 16.5 million more Americans are covered with some form of health insurance, cutting the uninsured rate by 35 percent.[17] 11.7 million Americans signed up though the health care exchanges, exceeding the White House's goal of 11.2 million but falling short of the Congressional Budget Office's (CBO) estimate of 12 million.[18]

The number of Americans with health care coverage will continue to increase with CBO and the Joint Committee on Taxation (JCT) estimating that 24 million and 25 million people will obtain exchange coverage each year from 2017 until 2024. Nonetheless, even with the ACA's expansion efforts, 31 million Americans will remain uninsured for a variety of reasons including immigration status, living in a state that opted out of Medicaid expansion, qualifying for Medicaid but not enrolling, or not purchasing insurance through an employer though it is available.[19] At the outset, however, it should be noted that despite all the changes to it, the individual market is relatively small compared to the total health insurance market. About half of Americans receive insurance through their employer while just more than a third

receive some sort of public insurance such as Medicare, Medicaid, or military health insurance. Only about 6 percent of Americans buy their own insurance on the non-group or individual market (though families can be covered on plans there as well).[20] Despite doom and gloom predictions, employers did not drop their employees *en masse* onto the individual market. For example, enrollment in employer-sponsored plans between 2014 and 2015 remained unchanged at 74 percent.[21]

ACA's Impact on Costs

Components of Insurance Costs

The cost of insurance to consumers consists of premiums and cost-sharing. Premiums are monthly, fixed payments that consumers for health insurance coverage. Before the abolition of medical underwriting, an individual's premiums were a function of how much risk the enrollee posed. Potential enrollees would submit to a battery of tests and questionnaires inquiring into past medical history. Insurers would charge those with pre-existing medical conditions prohibitively higher premiums or deny coverage altogether. Women could be charged more than men and the old could be charged considerably more than the young. As noted, the ACA eliminated such practices. Premiums routinely change from year to year (usually in one direction—up) and reflect how much the insurer expects to pay out in medical claims, administrative costs, and a target profit margin.[22]

Cost-sharing on the other hand consists of various out-of-pocket expenses including deductibles, co-pays, and co-insurance. Deductibles are fixed annual amounts that the enrollee must meet before insurance will cover their medical

costs. Co-pays are fees accrued at the point of service for prescriptions and routine tests while co-insurance is a percentage fee for a service or procedure. Consumers are generally faced with a trade-off between premiums and cost-sharing. Premiums are inversely related to cost-sharing, the higher the cost-sharing—the maximum amount the enrollee is responsible for before insurance will kick in—the lower the premiums generally.[23]

The marketplace for non-group or individual insurance classifies plans according to metals—bronze, silver, gold, and platinum. The metal reflects the amount of cost-sharing on the part of the consumer with bronze-level plans incurring the most (but with the lowest premiums) and platinum-level plans incurring the least cost-sharing (but with the highest premiums). Subsidies are available for those whose earning between 100 and 400 percent of the Federal Poverty Level (FPL)—$46,680 for an individual or $95,400 for a family of four—unless they live in a state that expanded Medicaid in which case they would be enrolled there. The plan most often used in premium comparisons is the second-lowest cost, silver-tier plan, which is also referred to as the benchmark silver plan because it receives the largest subsidies. For those between 100 and 250 percent FPL they can receive additional subsidies for cost-sharing as well but only if they purchase a silver-level plan.[24]

The subsidy is actually an advance tax credit. The enrollee estimates his or her income at the beginning of the year's enrollment period and when filing taxes for that year compares the estimate to the actual amount. However, the enrollee could be in for a surprise if he or she underestimated his or her income and would

thus owe more taxes. According to accounting firm H&R Block, 52 percent of enrollees for 2014 owe back a portion of their subsidy. The average amount paid is $530, which decreases their tax refund by about 17 percent. On the other hand, nearly one-third overestimated their income and received a refund—about $365—leading to an 11 percent refund increase.[25] In 2015, silver-level plans constituted 65 percent of marketplace purchases while bronze-level plans were 20 percent.[26] Additionally, 86 percent of enrollees—over 10 million people—receive some kind of premium subsidy. Of these, 8.8 million are in states with federally run exchanges.[27] But depending on the outcome this summer in the pending *King v. Burwell* case challenging the constitutionality of those subsidies, they could disappear.

Premiums in 2014—the First Year of the Marketplaces

The most robust look at growth in non-group premiums in 2014, the first year of the ACA's marketplaces, was done by the conservative-leaning Manhattan Institute. Analyzing data from 3,137 of the U.S.'s 3,144 counties, the study compared the five least-expensive plans in each state pre-ACA with the five least expensive plans post-ACA among three age groups—27 year olds, 40 year olds, and 64 year olds. The average nationwide premium increase was 41 percent from the year previous. The premium increases ranged from 91 percent, 60 percent, and 32 percent for each respective age group. In their study, women saw lower growth with 44 percent, 23 percent, and 42 percent premium increases for 27 year olds, 40 year olds, and 64 year olds respectively. 91 percent of all U.S. counties saw increases in premiums and women's premiums increased in 82 percent of them. As their Senior Fellow and Forbes Opinion Editor, Avik Roy, notes, these figures are pre-subsidy so

those who fall within the 138-400 percent of the FPL income bracket would see costs defrayed.[28] A study from HHS indicates that subsidies would alleviate 76 percent of the premium increase.[29]

But the less one's income exceeds 400 percent of the FPL, and the healthier one is, the more the rise in premiums due to the ACA's provisions will be felt. Indeed, "[e]xperts have long said younger, healthier Americans would likely pay more on the individual market, while older or less healthy folks would pay less."[30] And while subsidies can offset many increased costs for those that receive them, the premium rises are combined with tax increases—"a double whammy."[31] So, if one falls within the income brackets, the increase would be mitigated. But younger people just above the income limits, and therefore not receiving a health care subsidy, will feel the pinch. (According to recent data, only 2 percent of eligible persons above 400 percent FPL enrolled in the marketplaces because, without the potential of a subsidy, they didn't have incentive to. However, it doesn't mean they didn't purchase coverage but may have chosen to purchase insurance off the exchange.)[32]

Controversy

There is, however, skepticism regarding the merits of comparing pre-ACA with post-ACA plans as was done in the study by the Manhattan Institute. Because of the mandated minimum level of benefits and coverage required for ACA compliance, the plans on the individual market look very different from past plans.[33] According to the non-partisan Kaiser Family Foundation, the new benefits and changes to plans "make direct comparisons of exchange premiums and existing individual

market premiums complicated, and doing so would require speculative assumptions and data that are not publicly available."[34] In their own analysis of the first year's rates they didn't dispute that premium rates would rise as a result of the law, but noted "[w]hile premiums [varied] significantly across the country, they [were] generally lower than expected."[35]

Nonetheless, Manhattan Institute Senior Fellow Avik Roy makes a compelling argument against the reluctance to directly compare pre-ACA to post-ACA plans:

> First: it is precisely the cost of Obamacare's regulations—in the form of higher premiums—that I and my Manhattan Institute colleagues are attempting to analyze. If Congress passed a law requiring every new car sold in the U.S. to have a hybrid engine, the price of cars would go up, because hybrid cars cost much more than conventional ones. Even if you think hybrid engines are awesome, you wouldn't be able to get away with arguing that it's "apples and oranges" to compare prices in the old, conventional car market to the new, hybrid-mandated one. The mandate is responsible for the higher cost.[36]

As Don Stewart, deputy chief of staff for Senate Majority Leader Mitch McConnell points out, "'Lower than expected' is still not the same as lower. [. . .] Costs and premiums are still going up.'"[37] And he's right; President Obama repeatedly, and erroneously, promised Americans that premiums would be $2,500

lower after the passage of the ACA.[38] When costs are raised, in this case by mandated benefits and coverage requirements, those costs must be made up elsewhere. To use an old economic adage, "There ain't no such thing as a free lunch."[39] By seeking to correct glaring problems in American health insurance, the ACA cannot avoid increasing costs for some while making insurance more accessible and affordable for others.

While there was, admittedly, a marked jump in individual, non-group premiums when the marketplace exchanges went live in 2014, it was a one-time jump of that magnitude as the sickest and neediest Americans clamored for coverage they didn't have access to in the past. Indeed, "CBO and JCT anticipate that exchange enrollees in the future will be healthier, on average, than the smaller number of people who [obtained] such coverage in 2014."[40] Thus, it is very likely that whatever negative premium impact felt initially will be mitigated as the insurance pool diversifies, spreading risk and keeping premium growth in check.[41]

Moreover, it must be noted that past plans could only be priced lower precisely because they included practices that led to the push for health reform in the first place. As Mark Robison at the *Reno Gazette-Journal* counters, "If you compared pre- and post-ACA plans that included pregnancy coverage, let you keep dependents on your plan until age 26, or didn't limit payouts, drop you if you got sick or exclude you for pre-existing conditions, then those plans likely show lower premiums now."[42]

Premiums in 2015—the Second Year of the Marketplaces

Though premiums in the individual market followed past trends, rising slightly between 2014 and 2015, it was well within, and even below, historical precedents where annual premium growth could exceed 10 percent.[43] Kaiser's analysis of the premium differences between 2014 and 2015 showed a 2 percent increase in benchmark silver-tier plans and 4 percent increase in bronze level plans.[44] Consulting firm PricewaterhouseCoopers' (PwC) study found a 3.7 percent across in 17 states with finalized premium rates and the District of Columbia. Across all states, including those with preliminary premium rate announcements, the average increase was slightly higher at 5.7 percent. The average premium was $361.[45] A similar attempt to compare the second year's marketplace data to the first's by the Commonwealth Fund found an unusually low, 0 percent increase in marketplace silver-tier premium plans for a 40 year-old nonsmoker.[46]

In one of the most comprehensive analyses, The McKinsey Center for U.S. Health System Reform crunched data from 335 carriers. Additionally, they obtained 2014 and 2015 data from each county allowing for a rich comparison of 223,000 insurance plans from the first two years of the marketplaces. Their findings showed slightly higher premium growth than Kaiser's. According to their research, between the 2014 and 2015 open enrollment periods, gross premiums increased "by a median of 6 percent among the lowest-price exchange products in all tiers"[47] before subsidies were considered. For the lowest-price plans from 2014 that were refilled for 2015 the increase was larger—around 10 percent.[48] The cheapest plans had the

narrowest networks and the most highly managed care. If consumers were to reenroll in their 2014 plan for 2015, 85 percent would face a premium increase, with a median gross-premium increase of 10 percent. But if they shopped around instead of reenrolling in the same plan, 75 percent of 2014 enrollees had access to a lower priced plan—up to 10 percent less—in their same metal tier.[49]

Of course, that is not to say that the growth in premiums was uniform. Despite the nationally mandated coverage requirements, insurance is still largely a state-regulated affair with state-specific risk pools and rate setting.[50] In PwC's study, the national average for a benchmark silver plan was $314, ranging from $206 in Hawaii to $583 in Alaska.[51] But wide differences exist across states and even within states.[52] For example, in Colorado PwC showed average rates from 2014-2015 ranged from a 22 percent decrease to a 35 percent increase.[53] Southeast Alaska and Western Minnesota saw the largest increases at 34 and 43 percent for their benchmark silver and bronze plans respectively while Summit County, Colorado saw 45 and 40 percent decreases respectively according to Kaiser.[54] In the Commonwealth Fund's study finding no average growth in premiums, 10 states and the District of Colombia saw double-digit percentage premium increases while 14 states saw declines across all plans.[55]

The ACA included rate review provisions for insurers to justify "unreasonable" rate increases—though the term remains undefined in the law. But the power to approve those rates still resides with the states. States can modify requests, increasing the premium but not by as much as requested. Predictably, there is considerable state variation in the approval rates for premium increases.

"For example, Oregon approved 68.3 percent of recent requested rate increases, whereas Massachusetts approved only 14.2 percent."[56]

In order to attract insurers to the market in the early, volatile years as plans adjusted to their new enrollees, the ACA provided for temporary insurance protection measures. These measures reassured insurers that they would be protected against large losses thus encouraging them to lower their prices and attracting more insurers to the marketplaces.[57] And it seems to have worked; according to HHS, 2015 saw 25 percent more insurers participating on HealthCare.gov, the federal exchange website, from 2014.[58]

Indeed, premium growth in the second year was held in check by the increase in the number of providers competing in the individual market. For example, Georgia saw three large carriers—Cigna, Coventry, United Healthcare, and Time Insurance—enter the fray. As a result, premium growth for benchmark silver plans increased a mere 1 percent in that state from 2014-2015. Three new providers United Healthcare, Physicians Health Plan, and Harbor Health Plan competed in Michigan, inching premiums down 1 percent over the same period.[59]

Though the number of competitors was important in determining the average premium in a state, some providers carried disproportionate influence. The Commonwealth Fund found that in many states with double-digit premium increases the jump could be attributed to the choice of just one provider. The state with the lowest national premiums, Minnesota, lost one of its largest carriers, PreferredOne which also happened to have the lowest-priced premiums the year previous. This drove up the average premium in the state 14 percent for silver-level

plans and an average of 19 percent for all plans for 2015. On the other hand, the decision by Virginia-based Optima Health to drop their $2,000 silver-level premium—"nearly seven times the cost of the average silver plan"[60]—led to a massive 56 percent drop for all plans across the state and 49 percent for silver level plans.[61]

To put the most recent premium growth figures in the individual market in perspective, it is instructive to compare it to premium growth in other sectors such as employer-sponsored plans over the same period. In 2013, before passage of the ACA the average employer-sponsored premium increase was 3.9 percent. But in the immediate wake of the implementation of Obamacare in 2014 employer premiums rose 5.9 percent, only slightly from the previous five-year average of 4.8 percent.[62] This growth, which ranged from between 3 and 13 percent per year since 2000[63] and is well within year-to-year premium increases in that market. So, as we see, not every premium increase in the individual, or even the employer market for that matter, is due to the ACA.[64] Premiums have been going up well before it across all areas of health insurance.

But perhaps one of the most surprising findings about the ACA since its enactment, and the greatest indication that premium cost control measures are working, are the latest budget numbers released by the non-partisan Congressional Budget Office (CBO). Back in its original 2009 assessment of the law for 2015-2019, the last year of its then 10-year projection, CBO estimated the law to cost $710 billion. Remarkably, in its latest budget figures, CBO has now reduced that figure over the same period to $506 billion—a 29 percent decrease. The laws costs are

dropping quickly, in March it revised its January 2015 numbers, "[reducing] its estimate of the 10-year cost of federal insurance subsidies by 20 percent, and [...] new Medicaid costs attributable to the law [...] by 8 percent."[65] Indeed, slower than expected premium growth is cited as the reason for the change.[66] Subsidies which were to average $5,200 per person, because of lower premium growth, have been lowered to $3,960. "The budget office now estimates that the federal government will spend a total of $849 billion on insurance subsidies in the coming decade — $209 billion or 20 percent less than it estimated in January of this year."[67] Additionally, the agency has lowered the projected national deficit from $7.6 trillion down to $7.2 trillion—a 6 percent decrease.[68]

However, just like every premium increase cannot be attributed to the ACA, neither can every decrease. Before, but especially in the wake of the recession, the United States experienced an historic slowdown in health care spending. For example, from 2001 to 2007 health care spending increases from the year previous decreased from just below 6.2 percent 10 percent per year down to the Kaiser Family Foundation. That dipped to around 4.7 percent before bottoming out at 3.8 percent.[69] Nevertheless, there is wide agreement that the economic downturn played a role in lowered health care spending but disagreement as to what extent—anywhere between 37[70] and 77 percent[71] according to various surveys. A similar trend was seen across all OECD countries,[72] further suggesting that the economic downturn, and not the ACA alone, was largely responsible for the decrease. As the economy improves and as more Americans have access to insurers thus increasing demand for medical services—"absent other changes in the health care system" [73]—

spending will increase. It appears this is the case; from December 2012 to December 2014 annual increases in health care spending went up from 3.3 percent to 5.6 percent, the biggest jump since before the recession.[74] But even small changes can over the long run do much to contain costs. "For example, lowering the growth rate by one percentage point on average over the next decade means that total health spending would be almost half a trillion dollars lower than expected 10 years from now."[75] It remains to be seen whether the increases will stay low or return to previous levels.

However, the Kaiser Family Foundation suggests that lower-than-usual premium increases show that the structural changes enacted by ACA are indeed working and containing cost. In agreement, the Commonwealth Fund credits three factors—direct consequences of the ACA—to the "unprecedented" national premium flatline: "the design of the marketplaces, an increase in the number of competitors, and the risk stabilization programs for participating insurers."[76] PwC agrees that the structural changes aimed at delivering better quality care at lower costs are moderating US health care spending.[77]

Concerns Over Cost-Sharing

Of course, insurance costs consist of more than just premiums but also out-of-pocket costs such as deductibles, co-pays, and co-insurance. Before the ACA, it was not unusual for deductibles, or the amount that an enrollee must pay before their insurance begins to cover medical expenses, to be between $10,000 to $20,000 on the individual market.[78] However, the ACA capped out-of-pocket expenses at $6,600 for an individual or $13,200 for a family.[79] Nevertheless, the average

deductible in 2015 for a bronze plan—a lower premium but higher deductible—was $5,181 for an individual and $10,386 for a family, according to health insurance consulting firm HealthPocket. Silver plans had deductibles ranging from $2,907 for an individual to $6,010 for a family.[80] The deductible increases from 2014 were relatively modest ranging from $100 and $159 for an individual and a family respectively in bronze level plans and $20 for individuals on silver-level plans. Silver-level family plans, on the other hand saw a $68 drop on average.[81]

As with premiums, cost-sharing in plans varied considerably state to state. According to a survey by the Commonwealth Fund, the highest deductibles for silver-level plans were as high as $4,048 in Florida but as low as $1,775 in Vermont. Overall, deductibles went down in 20 states but increased in 26. In their analysis, they found the average deductible rose only 1 percent in the second year of the ACA's marketplaces, but with some states seeing hikes as high as 32. Washington DC saw the largest decrease deductible decrease at 16 percent.[82]

Though the uptick from 2014-2015 wasn't nominally large, those figures for non-group plans are still well beyond the IRS's parameters for classification as a high-deductible plan ($1,300 for individuals and $2,600 for families).[83]And while the caps on out-of-pocket expenses may be a welcome relief, deductibles on the individual market are still considerably higher than those in employer-sponsored plans where average deductibles for an individual were an average of $1,217 in 2014.[84]

While more Americans have access to insurance, it doesn't always mean they're getting the care they need if their cost-sharing requirements are out of

reach. In a recent survey of mid to low-income households, Kaiser found, that many do not have sufficient liquid assets to cover their deductible meaning they are still facing barriers to needed care.[85] Though healthy people who do not use services as much may not mind the deductible they can prove a real obstacle to those without such means. "Nearly 30% of privately insured, working-age Americans with deductibles of at least 5% of their income had a medical problem but didn't go to the doctor" according to Commonwealth Fund.[86] Kaiser also found about "a quarter of privately insured Americans don't have the savings to pay their deductibles."[87] 24 percent of households report not having enough savings to cover a mid-range deductible ($1,200 for an individual/$2,400 for a family) and 35 percent do not have enough for a higher-range deductible ($2,500 for an individual or $5,000 for a family). The numbers for those in lower income brackets are even more concerning with 55 percent and 68 percent not being able to cover their low and high-range deductibles respectively.[88]

Indeed, "[t]he estimates are conservative because they assume that people have all of their liquid assets available to pay their health-care bills. But most people must tap into their liquid assets to meet other obligations, such as their rent or mortgage, car repairs, or educational costs."[89] Interestingly, many consumers are overconfident in their ability to pay their medical bills. Despite a majority of respondents saying that paying their premiums and deductibles was relatively easy, for an unanticipated medical bill of $500, only 47 percent admitted they would be able to pay the bill in full.[90] More than half said they would have to borrow money, put it on a credit card or not be able to pay it at all.[91] With an average of less than

$6,000 in savings and a quarter of Americans with no savings at all, as Drew Altman, president of Kaiser Family Foundation writes, "It's no wonder that collections for medical debt represent half of all bill collections."[92]

Rising premiums and cost-sharing (though modest in historical, absolute terms) are compounded by a "convergence of [other] trends building for years"[93] including stagnant incomes which have not kept pace with medical costs.[94] While US health care spending has grown to nearly 20 percent of GDP from 5 percent in the 1960s, the average wage in 2014 is just barely over what it was in 1964—$19.18.[95] This explains why even though health care spending is at its lowest levels in history, most Americans do not perceive it.[96] In its latest poll the Kaiser Family Foundation found that despite record-low levels of health care spending, only 3 percent of Americans said health costs had been rising slower than usual while 52 percent said they had been growing faster than usual.[97] In addition to rising health care costs, other necessary expenses such as college and housing costs continue to rise faster than other sectors of the economy, further putting the squeeze on American families.[98]

The shifting of costs onto consumers was not precipitated by the ACA and "is very much an artifact of the pre-ACA health care landscape."[99] Moreover, besides the individual market, high-deductible plans have been seen across all sectors of the health insurance market. For example, according to the Kaiser Family Foundation, 80 percent of workers now have some sort of deductible, up from 55 percent just eight years ago.[100] Deductibles for employer-sponsored plans have more than doubled in the past eight years.[101]

Health economists and insurers point out that cost-sharing is intended to encourage consumers to shop around and discourage unlimited use of health services in defense of a principle known as moral-hazard. Towards that end, though the ACA sought to increase price transparency for the health care industry, only a small portion of consumers appears to be taking advantage of it. 66 percent of respondents to a recent Kaiser survey report difficulty knowing what doctors or hospitals charge for treatments or procedures.[102] Only 3 percent used price information to inform their physician's decisions.[103] Indeed, less than 10 percent of people "used information about prices, most commonly in relation to health plans."[104]

And for non-emergency, non-critical care that may be the case. But if one is facing a medical emergency, price comparison is not a realistic expectation. Though the ACA provides for free preventative care screenings, consumers are either unaware of these benefits or know that wouldn't be able to afford to do anything if something turned up.[105] Moreover, the consumer is also not in a position to know whether the mole in question or the ache is an indication of something more serious or not.[106] But delaying care because of finances can exacerbate a condition that might have been cheaper and easier to treat had it been caught early on. One doesn't usually shop for health information unless one needs it and by then it may be too late to afford (literally) oneself the luxury of shopping by price; you take what you can get when an emergency hits and think of how to pay for it later.[107]

Conclusion

Increasing coverage to a wider swath of Americans—in which the ACA has undoubtedly succeeded—is not without trade-offs. From the above review, it is clear that premiums rose, in some cases significantly, in the individual market after significant restructuring. But after the initial bump, the most recent year showed little to no growth and is well within or below historical precedents. Moreover, the ACA's fiscal soundness has only improved since its passage, continuing to fall below previous cost estimates.

But only focusing on premiums without addressing the increasing shift to consumers through high-deductibles ignores a significant and growing problem in American health care. U.S. families are facing real economic pressure and to the extent that they have seen decreased wages that have not kept pace with other sectors of the economy, coupled with the move to high-deductible plans, they are rightfully upset. Because of the confounding effect of the recession, it is difficult and too early to know the ACA's exact impact on curbing costs. But unilaterally blaming the ACA for every insurance or medical difficulty is mistaken. The problems existed well before the ACA and, one might argue, if they haven't been ameliorated, at least they haven't been exacerbated. There are far greater forces at work and the ACA is but one attempt to relieve some of these pressures and rein in insurance costs. The ACA is problematic to the extent that it has not addressed, though, the problem of high-deductibles, which, though more Americans have access to insurance, many still cannot afford care.

There certainly is room for improvement. But rather than repeal the law wholesale, as some would like, it should have time to work itself out and be reformed as need be. As Tom Harkin the former chairman of the Senate HELP Committee characterized it, the ACA is a "starter home."[108] The ACA should be the beginning of a conversation about health care in America, not the end of it.

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Andrew Izatt

Internship Reflection

05/11/15

My internship at Orrin Hatch's office was a life-changing experience. More than anything else in my undergraduate career it helped me to realize what I do and do not want to do. I enjoyed the time I spent there. I met amazing, hard-working, driven people with a real passion for politics. I saw the inner workings of a high-profile Senate office and what work on the Hill entails. I have been interested in health care policy for a while and the debate surrounding it. Thanks to my internship and my project, I was able to dive headfirst into the material and begin to get my head around the complex and bewildering world or health care in America. Orrin Hatch holds prominent positions of the Finance and HELP Committees and so has a large staff dedicated to such issues. Fortunately, I learned earlier rather than later that such a job is not one I would find fulfilling long-term. I would recommend that students do internships early and do more than one. This is my biggest regret from college. I wish I had interned earlier on in my career. It would have helped me to hone in on my potential career path and given my path of study more direction.

I had difficult, at first, with narrowing down my topic. As with most policy issues, the directions one might go and the ground one might cover are dizzying. Focused and specific topics, while initially daunting—how will I fill the page?—quickly work themselves out as research uncovers new and exciting new directions. I was amazed at how one question led to another and I was able to answer questions I myself generated.

Becoming an "expert"—I use the term loosely—on a topic is empowering. Through deep reading, writing, and thought it is amazing how much one learns.

Because I started early, I often rested on my laurels. I felt so ahead that before long I had fallen behind. The earlier you finish, the more you can tweak and fine-tune your paper and discover problems and issues before they become crises. Luckily that didn't happen but taking other classes at the time through IOGP was a hindrance as time I could have spent on my paper was spent fulfilling their requirement.

Regarding the topic at hand—insurance costs on the individual market after the ACA—I didn't have a particular position. I went into it with an open mind and no preconceived notions. While I had some biases and opinions, I went out of my way to read materials and positions that disagreed with me. I have spent considerable time reading materials from all over, from primers on the topic to the latest research. I sought out the best data and the best sources I could in order to arrive at an analysis and opinion not derived by ideology or political cheerleading. I sincerely wanted to know how insurance costs had changed in the wake of this law, which has been so fraught with partisanship. I hope my paper reflects an honest balance and attempt to present the matter as fairly and objectively as possible. The questions was generated in large part by my own parents' recent experience purchasing health care, their complaints with the process, and the "sticker shock" they felt. While I sympathized with them, I wanted to understand exactly why insurance costs were so high and how the ACA had impacted them.

One challenge I faced was the distance from the university It was difficult to write my paper from afar. It made me feel less accountable and being so far away made procrastination that much more tempting. While my immediate supervisor was better than

most in my office I was often left alone, especially early on at my internship, with nothing to do. It took real discipline to take time for my project when it was tempting to do other things not related. With the due date being so far away, I thought, I felt like I had all the time in the world. But the days have a way of getting away from you and before you know it, you're graduated.

I would stress for a prospective intern or thesis proposal is to start early. It is easy to procrastinate and think that you will have time later but in my internship, especially as time went on, I had increasingly less and less time to complete my work. Luckily, I know my own working habits and knew that I would be burnt out by the time May came around and started writing and researching in earnest. I was also fortunate that my internship and field of interest coincided so closely.

I would also recommend taking advantage, again, early on, to talk to and receive feedback from your supervisor. It is easy to avoid bothering them because they are so busy but they are focused on the topic you're researching and have lots of perspective to add. My supervisor and others were enthusiastic and encouraging about my project and more than once lent me a hand with sources, topic direction, etc. I am grateful for my Legislative Assistant, and fellow USU alum, Matthew Richardson. He was more than helpful and willing to sit down with me to talk about things.

While I had regular communication with my advisor, Shannon, and sent some rough drafts to another mentor, Frank Caliendo, both of whom graciously took time to read my paper and give me feedback, it was more difficult and easy to put it off (on my part) than meeting in person. By meeting in person, it is easier and quicker to ask and give feedback to issues as they arise. It is more than possible to do such an involved

project but definitely easier to do in person. I didn't think of it until it was too late but Skype or Google Hangouts might have be an comparable substitute for the face-to-face meetings.