ISSUE BRIEF

The Affordable Care Act – Against the Odds, It's Working

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This issue of the *North Carolina Medical Journal* focuses on the 10-year anniversary of the Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010. Since its inception, the ACA has been highly controversial. Yet, it has contributed to positive improvements in our health care system. The ACA expanded health insurance coverage to more of the uninsured, made investments in prevention and in improving quality of care, and started our journey toward value-based care. This issue brief touches on how the law has been implemented in North Carolina, along with an assessment of the successes and failures of the law. It is followed by more detailed commentaries on specific aspects of the law and its implementation in our state. While much has been accomplished in the last 10 years, more is needed to achieve our goals of an affordable, equitable, and accessible health care system—one that promotes positive health outcomes while reducing unnecessary costs.

Introduction

As designed, the Affordable Care Act (ACA) attempted to address some of the major flaws in our existing health care system including access to care, poor health outcomes, inconsistent quality, and high health care costs. This issue brief focuses on these four problems. It includes an overview of how the ACA attempted to address the problems, how it has been implemented in North Carolina, and an assessment of both the successes and failures of the ACA. This issue brief is followed by more detailed commentaries that expound on specific aspects of the law and its implementation in North Carolina.

Increased Access Through Expanded Insurance Coverage and Provisions to Address Provider Supply

When the ACA was first being debated, the country was in the midst of a major recession. Many people had lost coverage, and others were excluded from coverage due to preexisting conditions. Nationally, more than 46 million non-elderly individuals (almost 18% of the population) lacked health insurance coverage in 2010 [1]. Others who had coverage were afraid of losing it. Thus, a key provision of the ACA was to expand coverage to more of the uninsured.

The ACA built on our existing public and private health insurance system. As Zachary describes more fully in her commentary, the ACA would have required all states to expand Medicaid to cover most adults with incomes up to 138% of the federal poverty level (FPL) [2]. It mandated that large employers offer affordable coverage to their employees or pay a tax penalty. The ACA also created an individual insurance mandate, requiring that most individuals have health insurance coverage or pay a tax penalty. It provided advanced premium tax credits and cost-sharing subsidies to make coverage more affordable to some lower-income families without access to other affordable coverage. The ACA also created new health insurance Marketplaces where individuals could shop for comprehensive coverage, determine whether they were eligible for subsidies, and then enroll online. And it allowed parents to keep children on their health plans until they reached age 26.

The ACA also added other consumer protections. It prohibited health plans from denying coverage or charging people more based on their preexisting health status. It included a comprehensive set of benefits offered in the nongroup and small employer market. And, the law included out-of-pocket limits on the amount of cost-sharing a person or family would need to pay each year in deductibles, coinsurance, or copayments.

From the start, this legislation has been highly controversial [3]. Perkins, in her commentary, notes that several lawsuits were filed challenging the ACA on the day of its passage [4]. The first to reach the US Supreme Court, *National Federation of Independent Businesses v. Sebelius*, challenged the constitutionality of the individual mandate and Medicaid expansion [5]. The Supreme Court upheld the individual mandate but effectively made Medicaid expansion voluntary for the states. Opponents have since brought lawsuits challenging other aspects of ACA. This fall, the Supreme Court will hear arguments in *Texas v. California*, which has the potential of striking down the entire law. If the law is struck down, more than 17 million people will lose Medicaid

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coverage, almost 10 million people will lose subsidies helping them purchase coverage in the Marketplace, 2.3 million young adults will lose access to their parents' coverage, and approximately 54 million people could lose coverage due to preexisting conditions [6].

As Stallings discusses in her Spotlight on the Safety Net column, North Carolina was largely successful in enrolling uninsured individuals into the Marketplace through NC Get Covered, a collaborative effort of navigator and assister organizations, licensed agents and brokers, insurance companies, government agencies, and others [7]. North Carolina has consistently had the fourth-highest enrollment among all states [8]. Linker and Gerald, in their Focus on Philanthropy column, elaborate on the important role that state and national foundations have played in creating the infrastructure for North Carolina's enrollment success [9]. Bell, in his sidebar, also notes how the ACA helped reduce racial and ethnic disparities in health insurance coverage, albeit not as much as could be if the state chose to expand Medicaid [10]. As numerous commentators in this issue note, the decision *not to* expand Medicaid excludes thousands of North Carolina families from affordable coverage, perpetuates racial and ethnic disparities, and hurts the financial bottom line of many of our safety net providers [2, 10-12]. North Carolina is one of only 12 states that have chosen not to expand.

Despite some of the problems created by the Supreme Court's decision to strike down mandatory Medicaid expansion, nationwide the ACA helped reduce the numbers of nonelderly uninsured by almost 20 million people, from approximately 46.8 million in 2010 to 26.9 million in 2016 [1]. However, the numbers of uninsured started to increase after the 2016 election, despite a robust economy (when we would normally expect more people to gain coverage). Nationally, the numbers of nonelderly uninsured increased by more than 2 million people between 2016 and 2019 (and by more than 100,000 in North Carolina) [1]. Others lost comprehensive coverage. This is due, in large part, to policy changes at the national level intended to undermine the ACA [13]. This includes the Congressional repeal of the individual mandate, the Trump administration's drastic cuts for outreach, education, and insurance assisters, and new regulations expanding the availability of short-term limited duration plans (Figure 1) [1, 13].

These efforts to undermine the law have actually increased the law's popularity, as focus shifted to the number of people who would be hurt if the law were repealed [3]. The height of the law's unpopularity was in 2014, after the coverage provisions first went into effect [14] (Figure 2). But in July 2020, more than half of the public supported the law, while only 36% opposed [14]. Support may continue to grow as more people lose employer-based coverage due to COVID-19 and turn to the Marketplace or Medicaid for coverage. Holmes, in his Running the Numbers column in this issue, estimates that approximately 250,000 North Carolinians lost health insurance coverage between March and August 2020 due to COVID-related job loss [15].

In addition to the insurance coverage provisions, the ACA included other efforts to expand access, such as increasing funding for community health centers. Shank and Riley, in their commentary, note that North Carolina was able to increase the number of community health centers from 27 in 2010 to 42 in 2018, and service locations from 163 to 278 during the same time period [11]. North Carolina health centers also used ACA funding to expand the array of services they could provide, increasing the availability of mental health, addiction, and oral health services.

The ACA also expanded funding for the National Health Service Corps (NHSC), which provides scholarships or loan forgiveness to certain health professionals willing to prac-

FIGURE 1.
The Impact of Different ACA Policy Initiatives on the Percent Uninsured [1, 12]

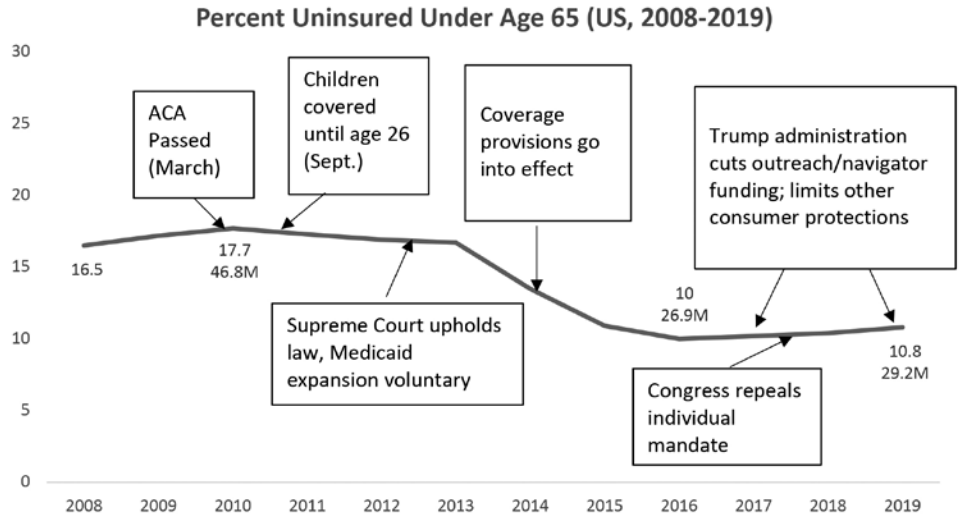
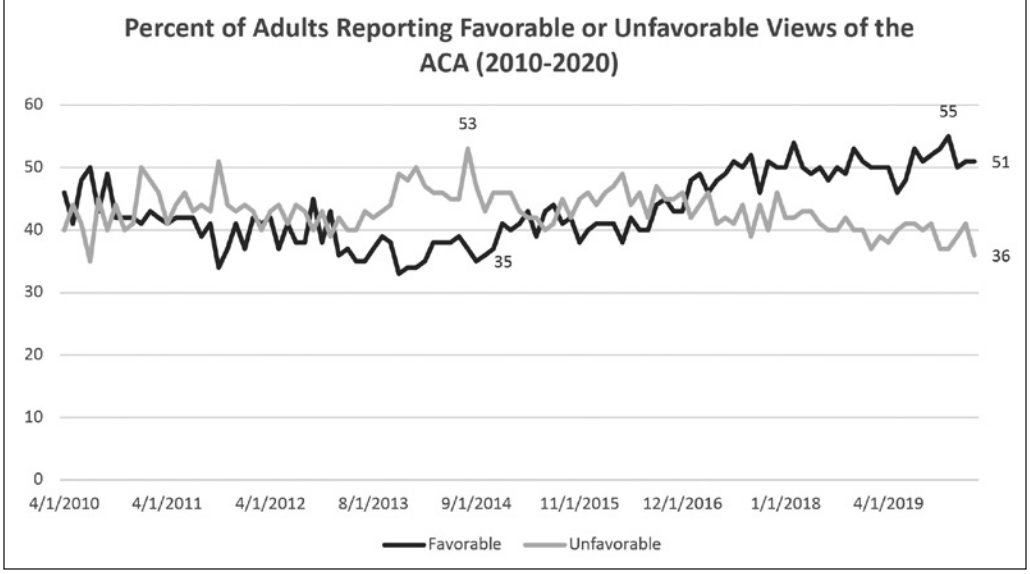


FIGURE 2.
The Public's View of the ACA Over Time [13]



tice in health professional shortage areas. As Fields and Resendes discuss in their sidebar, the number of health professionals supported through NHSC funds increased from 66 providers/year in 2009 to approximately 241/year from 2010 to 2019 [16]. These funds helped recruit much-needed primary care, oral health, and behavioral health providers to rural and urban underserved communities.

Improving Population Health

Despite spending more on health care than any other country, the United States has worse health outcomes than most other industrialized nations. The United States historically ranks in the bottom third of most comparable countries in key health indicators, including life expectancy at birth, infant mortality rates, and potential years of life lost [17]. North Carolina typically ranks in the bottom half of the states in most health indicators (ranking 36th out of 50 states and DC in the 2019 America's Health Rankings Report) [18].

The ACA included several provisions aimed at improving the health of the country. As Brody and colleagues at the NC Division of Public Health describe, the ACA included provisions to develop a National Prevention Strategy, provided coverage for certain clinical preventive services with no cost-sharing, and created a Prevention and Public Health Fund (PPHF) [19]. Funds from the PPHF were used in North Carolina for tobacco prevention, access to healthy foods and active living, injury and violence prevention, maternal and infant home visiting programs, and local public health infrastructure.

In addition to public health prevention efforts, the ACA included other provisions to improve population health. For example, the ACA required nonprofit hospitals to meet new community benefit obligations to maintain their tax-exempt status. Arledge and Braasch describe how this requirement created opportunities for hospitals, public health, and other community groups to work together to develop a regional community health improvement plan in Western North Carolina [20]. The WNC Healthy Impact network used data to identify community health needs, set priorities, and create a shared set of accountability measures. Local hospitals, nonprofits, and philanthropic organizations tailored their investments around these priorities. This effort has become a model for other regions in the state.

Increased Focus on Quality of Care

As noted earlier, the United States lags behind other countries in health outcomes. But health outcomes are influenced by a host of factors outside the control of the health care provider, such as social and environmental factors and lifestyle choices. However, the United States has a mixed record on quality of care, even when focusing on quality measures that are more directly in the control of health care providers. For example, the United States has higher rates than other comparable countries of deaths amendable to health interventions; medical, medication, and lab errors; obstetrical trauma during vaginal delivery; and hospital admissions for preventable conditions [21]. In contrast, the United States does better on some measures of quality, such as 30-day mortality for heart attacks and strokes [21].

The ACA included several provisions aimed at improving health care quality. It included both mandates and financial incentives to ensure that that providers report certain quality measures. The Hospital Readmissions Reduction Program was one of the first of these initiatives implemented. Under this program, hospitals could face a penalty of up to 3% in Medicare payments if they had excess readmissions for heart attacks, heart failure, or pneumonia. Later, the program was expanded to include excess read-

missions for chronic obstructive pulmonary disease, hip or knee replacement, or coronary artery bypass grafting. Of 117 North Carolina hospitals, 68 were penalized in 2020, 14 had no penalties, and 35 were exempt from participation in this program [22]. According to MedPAC, a nonpartisan legislative agency created to provide Congress with advice on the Medicare program, the Hospital Readmissions Reduction Program led to a decline in hospital readmissions without an increase in risk-adjusted mortality [23]. The ACA also created the Hospital Value-Based Purchasing Program, which includes both payment rewards and penalties based on quality [24]. Pope, in his commentary, provides further information about the Hospital Value-Based Purchasing Program, along with the overall impact of the ACA on hospitals [12].

The ACA required other providers and health insurers to report on quality measures as well. Some of these data are available through Medicare provider comparison websites [25]. Health insurers participating in the Marketplace also had to report data on quality and patient satisfaction, which are publicly available. While more data are available to help individuals identify high-quality providers or plans, most consumers do not use quality or price information to select providers [26].

These efforts to improve quality have shown some success, although some argue whether the improvements are due to the ACA [27]. Further, collecting and reporting these data comes at a cost. One study noted that physicians and their staff spend an average of 15 hours/week collecting and reporting data on required quality measures, amounting to more than $15 billion annually [28].

Reducing Unnecessary Health Expenditures by Changing Payment and Delivery Systems

The United States is an outlier in the amount we spend compared to what we obtain in terms of health outcomes. Thus, another goal of the ACA was to increase the value of the dollars we invest in the health care system by improving health outcomes and reducing unnecessary expenditures.

Our current system relies heavily on fee-for-service (FFS) payments to providers. The FFS system pays providers for every visit, procedure, and test they provide. FFS rewards volume, which can lead to overuse of unnecessary tests or procedures and care fragmentation. Berwick and Hackbarth estimated that between 21% and 47% of all health care spending is wasted [29]. Of this, between one-third and one-half could be attributed to failures of care delivery, failures of care coordination, and overtreatment.

The ACA attempted to address this by changing the way we deliver and pay for health services. It created a new Center for Medicare and Medicaid Innovation (called the Innovation Center), charged with testing and evaluating new payment and delivery models aimed at improving quality and health outcomes and reducing health expenditures. Between 2010 and 2018, the Innovation Center tested 37 new models of care, most of which focused on one of three models: primary care transformation, episode or bundled payments, and Accountable Care Organizations (ACOs) [30].

Primary Care Transformation

Most of the primary care initiatives in the ACA aim at moving primary care practices toward Patient-Centered Medical Homes (PCMH). PCMHs typically include a diverse team of health professionals who provide patient-focused comprehensive primary care services that actively engage patients in their own care. Another key component of PCMHs is the active use of electronic health records (EHR) and information supports to improve quality of care and patient outcomes. PCMHs often combine FFS infrastructure with care management fees and bonus payments for meeting certain performance or quality metrics.

The Innovation Center tested a number of different PCMH models; North Carolina practices participated in two. Eighteen of North Carolina's community and migrant health centers participated in the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, aimed at helping FQHCs achieve enhanced PCMH recognition [31]. One Durham-based primary care practice participated in the Independence at Home initiative, which tested whether home-based primary care services for patients with chronic illnesses and functional limitations would help improve health outcomes and reduce costs.

Bundled or Episode-of-Care Payments

A bundled payment is a single payment to a group of providers that covers the costs of all the services needed to treat a particular condition or procedure. Theoretically, this single payment would encourage providers to work together to better coordinate care and reduce costs so as to share in the savings. Again, CMS tested several different bundled payment models. The largest effort was the Bundled Payments for Care Improvement (BPCI) initiative. A number of North Carolina practices participated in different bundled care demonstrations. In 2018, five clinics or health systems participated in BPCI Model 2 (bundling payments for acute care hospitals and post-acute care) and seven in BPCI Model 3 (post-acute care services only) [32]. Seven different North Carolina providers are currently participating in the Advanced BPCI demonstration, which is a two-sided payment system, sharing both savings and losses [33]. CMS also developed a bundled payment initiative for knee and hip replacement. Currently, seven North Carolina hospitals are participating in this Comprehensive Care for Joint Replacement initiative [34].

Accountable Care Organizations (ACOs)

ACOs include groups of providers that agree to coordinate all the care needed by a group of patients. In most models, providers continue to receive FFS payments but can share in savings if they meet certain quality and performance metrics and achieve savings below a spending target. More

recent models have moved to two-sided risk models. The Medicare Shared Savings Program (MSSP) was permanently authorized as a delivery option within Medicare; the other models are demonstrations with the Innovation Center. The MSSP is, by far, the largest of the Medicare ACO models. Of the 517 MSSP programs operating throughout the country, 34 operate in parts of North Carolina in 2020 [35]. Most of the ACOs operating in North Carolina are shared savings models; only about one-quarter are in two-sided risk models.

As Crook and colleagues note in their commentary, these different payment and delivery reform models have met with limited success [36]. To date, ACOs have been the most successful of these models. However, as Crook notes, although the outcomes of these efforts have been modest, it may be too soon to fully assess the potential for these changes to improve value. Health systems need time to develop the infrastructure required to support these payment and delivery models. Further shifts away from FFS are needed to achieve greater savings. Even with these modest cost savings, some experts credit the move to value in Medicare, Medicaid, and private insurers as one of the reasons for the lower-than-expected growth in per capita health care spending since the passage of the ACA [37].

More Work is Needed to Achieve the Goals of Improved Access, Population Health, Quality, and Lower Costs

In the last 10 years, we have made significant progress in covering more uninsured people, reducing health disparities in insurance coverage, and expanding access to care for underserved populations. We have made headway in shifting our health payment system from one that pays for volume to one that pays for value. We've seen modest improvements in health outcomes, quality of care, and lowered health expenditures. Much of this success is attributable to the ACA.

Nonetheless, the ACA needs to evolve if we hope to achieve more of its lofty goals. The ACA was never designed to cover everyone. Low-income individuals in states like North Carolina that have not expanded Medicaid have few options for coverage. Health insurance is still far too expensive for people who do not have substantial premium- and cost-sharing savings in the Marketplace. States that have more competition among health plans generally offer lower premiums [37]. However, some states—like North Carolina—offer little competition. In the past, the state only had one insurer offering coverage in most of the state [38]. Options currently being discussed at the national level could address some of these problems by creating public health insurance options to compete with private insurers in the Marketplace, expanding subsidies to make coverage more affordable, and automatically enrolling low-income individuals in the public option [39]. This is particularly important with the current COVID-19 pandemic, as so many people have lost their jobs and their insurance coverage.

As the pandemic has made abundantly clear, we have not invested heavily enough in the public health infrastructure needed to protect public health. Yet, much of the ACA funding for prevention—the Prevention and Public Health Trust Fund—has been siphoned off for other purposes. To improve the health of our country and our state, we need to invest more heavily in prevention and other non-medical factors that influence health, such as affordable housing, food security, and education.

Finally, we are beginning to learn what works in our move to value-based care. More time is needed to determine whether these new payment models will lead to meaningful improvements in health care quality and health outcomes and help reduce unnecessary expenditures. Yet, there is cause for cautious optimism. Between 2010 and 2018, our average overall health care expenditures have risen less rapidly than in the prior 20 years. The ACA may be contributing to this restrained health care spending, but more is needed to further curb rising health care costs. NCMJ

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