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THE AFFORDABLE CARE ACT

In 2010, about 50 million Americans lacked health insurance (Department of Health & Human Services 2011). Some of them were healthy individuals opting to save money and face the risk of illness alone. There were others whose jobs did not provide insurance, or had illnesses or health histories that made purchasing health insurance expensive or impossible. People with these so-called “preexisting conditions” who could not find coverage through an employer or government program often declined to pay the high premiums required.

The Affordable Care Act (ACA) of 2010, commonly known as Obamacare, preserves the overall patchwork nature of American health insurance but dramatically reforms the market for individual insurance policies. On the one hand, it makes insurance more accessible for the low-income and the sick, but it also imposes a penalty on those still without insurance.

This chapter only scratches the surface of the ACA. A fuller treatment would need its own text and another few years of data, as the consequences of the ACA continue to play out. We focus here on the main policy aspects of the ACA and their relationship to key topics in health economics. In the chapter’s second half, we discuss some emerging evidence on the health reform’s impact and the current state of the ACA.

1.1 The Structure of the ACA

Economist Jonathan Gruber, who contributed to the design of the Affordable Care Act, describes the law as a “three-legged stool” (Gruber 2011).¹ Those three legs are:

- Regulations on the individual market
 - Insurers can no longer charge the sickly more or refuse to cover customers based on “pre-existing conditions.”
 - All insurance plans must cover a minimal set of essential health benefits.
- The individual mandate
 - Everyone must have health insurance or pay a penalty.
- Policies making insurance more affordable for the low-income
 - Medicaid expands to cover the poor in addition to the very-poor, and the government offers subsidies to those with low income but are not Medicaid-eligible.

Like a stool, the ACA was intended to rely on all three legs in order to stand. On its own, restricting insurers from pricing on customer risk would trigger an adverse selection death spiral. Hence, the individual mandate ensures that the healthy stay in the market and pool with the sick. But mandating everyone buy health insurance inflicts a regressive

¹ A couple ACA components such as allowing children to stay on their parents’ insurance plan until age 26 fall outside the three-legged stool analogy, but the key components fit nicely within Gruber’s classification.

financial burden unless the government also subsidizes the purchase or otherwise makes insurance more affordable.

The stool's stability depends critically on the specifics of each policy component. What is the minimum level of coverage necessary to fulfill the individual mandate? Which groups are eligible to receive subsidies? Under the ACA's regulations, will insurers be able to profitably offer plans?

In the following sections, we discuss each leg in greater detail. One recurring theme is that though the overall ACA has withstood attempts to repeal, each leg has been whittled away in the years since its passing and especially under the presidency of Donald Trump. Some elements of the ACA remain, while others such as the individual mandate have been effectively overturned. By describing first how interconnected each policy leg is, we preview the potential consequences of each leg cracking.

Regulating the individual & small group insurance market

Prior to the ACA, buying insurance on the individual market in the U.S. was an arduous process. You would have to contact a private insurer, undergo a medical exam from an insurer-approved physician, and answer extensive questioning about your family's medical history. The insurer's goal is to unearth any and all likely health risks to protect itself from being on the hook for costly medical bills. In other words, insurers looked for any **pre-existing conditions** that could lead to high health care expenses.

In most states and in most cases, insurers were allowed to discriminate based on these pre-existing conditions (Clemens 2015). Patients deemed the most risky were then offered only plans with high premiums or were refused coverage altogether. Alternatively, the insurer might offer general coverage but not cover expenses related to specific preexisting conditions. Furthermore, the opacity of each insurer's pricing procedure (known as *underwriting*) impeded comparison shopping.

The ACA overhauled this process for buying insurance for individuals entirely. First, it restricts how insurers are able to price plans. Individual plan premiums may now vary only by the customer's location, age, and tobacco use (Kaiser Family Foundation 2013b). Critically, insurers are no longer able to take into account other risk factors (e.g. pre-existing conditions such as patient history of heart disease, obesity level, family medical history, etc.) in pricing plans. So within the same local geographic area, non-smokers of the same age now have the same access to health insurance plans regardless of their current health.² Because these rules prohibit insurers from refusing customers based on health status, they are also known as **guaranteed-issue** rules.

Another way to think about this restriction on underwriting is: before the ACA, the insurer presented each customer with a personalized "menu" of insurance plans. The insurer adjusted both the variety and price of menu items depending on the customer's likely health costs, offering generous plans and low premiums for the healthy and the opposite for the at-risk.

The ACA requires that similarly-aged people in the same local marketplace all receive the same menu, administered through a state-based health insurance exchange. This "shared menu" approach is also known as **community rating**. (See Chapter 17 for more

² The ACA still permits insurers adjust prices within certain ranges based on geography, age, and smoking status.

about how community rating works in health insurance markets in Bismarckian health systems.)

The “menu” analogy also helps reveal winners and losers resulting from this particular ACA policy. The sick now see the same menu as the healthy. But the healthy no longer enjoy their special, cheaper menus and instead effectively subsidize the sick. On the other hand, reclassification risk is reduced for the healthy and sick alike – the potential financial burden from becoming sick is lower because insurers can no longer exclude sick customers (Handel et al. 2015).

The ACA also regulates plan characteristics. First, the government defines a list of “essential health benefits” that all plans must cover. These benefits were not always included in the plans sold on the individual health insurance market before ACA regulations went into effect (Table 1.1).

Table 1.1. *List of essential health benefits that ACA requires all health insurance plans to cover (Centers for Medicare & Medicaid Services 2018).*

Ambulatory patient services
Emergency services
Hospitalizations
Maternity and newborn care
Mental health and substance use disorder services
Prescription drugs
Rehabilitative and habilitative services and devices
Laboratory services
Preventive and wellness services and chronic disease management
Pediatric services

Secondly, the ACA categorizes plans into groups based on how much of expected health costs the insurer actually covers. This measure of generosity known as the plan’s *actuarial value* is determined by the fraction of total medical expenses paid by the insurer (as opposed to paid out-of-pocket by the patient). The most generous plans covering 90% of costs are rated Platinum. Plans with lesser actuarial values are rated Gold, Silver, or Bronze. Plans with actuarial value below 60% are generally banned from the marketplace.³

$$\text{Actuarial value of insurance plan} = \frac{\text{average expenses paid by insurer}}{\text{average total health care expenses}}$$

While premiums differ by location, on average, the Silver plan cost \$4,583 annually in 2016 for a single person (Levitt et al. 2016). Later we discuss the reforms used to make plans affordable for the low income, as well as reforms intended to incentivize insurers to actually offer such plans.

The ACA also bans lifetime spending limits. In the past, plans could set some lifetime cap on costs the insurer would cover. For example, for a given disease, an insurer would

³ Some states permit some exceptions to this minimum generosity level, and in some cases, customers were allowed to grandfather in their pre-ACA plans.

Table 1.2. *Phase-in amounts of the individual mandate penalty. The actual charge is the greater of columns (a) and (b). This penalty amount was reduced to zero in 2019.*

Year	(a) Flat Fee (per person)	(b) % of Household Income
2014	\$95	1.0%
2015	\$325	2.0%
2016	\$695	2.5%

After 2016, the penalty amount for those making more than \$27,800 was 2.5% of their income.

Source: Kaiser Family Foundation (2013a).

only cover the first \$1 million dollars in expenses, regardless of whether those costs all occurred in a single year or over 30 years. The ACA bans these caps altogether, reducing customers' exposure to catastrophic bills in extreme cases.

The individual mandate & the employer mandate

The ACA's regulations on the insurers mean the sickly can reliably gain access to health insurance, but those same regulations also expose insurers to potentially-ruinous adverse selection. If insurers can no longer refuse sick customers or charge them with higher premiums, what prevents everyone from waiting to fall ill *before* buying insurance? Insurers feared that only the sickly would buy insurance, which would raise premiums and ignite an adverse selection death spiral (see Chapters 8-10).

Policymakers sought to avert this outcome by requiring everyone participate in the market, the healthy alongside the sick. Known as the "individual mandate," this tactic aims to prevent the market unraveling by literally forbidding selection out of health insurance.⁴

In theory, this seems like a straightforward solution to adverse selection, but how would a mandate actually be enforced? Policymakers settled on a penalty, enforced by the Internal Revenue Service (IRS), on those without health insurance. Once the penalty fully phased in by 2016, the actual amount was either the greater of 2.5% of household income or \$695 per person (Kaiser Family Foundation 2013b). This penalty amount was scheduled to increase yearly by a cost-of-living adjustment to keep pace with inflation. Table 1.2 lists mandate penalty amounts during the phase-in period.

To achieve its goal of reducing adverse selection, the individual mandate has to deter low-risk, healthy types from leaving insurance markets. One concern is that the penalty

⁴ The individual mandate was also challenged on legal grounds. Critics questioned whether the federal government could mandate its citizens purchase insurance. Lawyers drew a distinction between federal laws forbidding actions (e.g. outlawing murder) and laws requiring actions (e.g. buying health insurance). One of the most memorable lines of questioning asked: if the federal government can mandate people buy health insurance, can it also mandate people buy broccoli? In *National Federation of Independent Business v. Sebelius* (2012), the U.S. Supreme Court ultimately upheld the constitutionality of the individual mandate as part of the government's taxation powers. However, this same court decision reversed the ACA's requirement that states expand their Medicaid programs. We discuss next how this decision undermines the ACA's efforts to make health insurance more affordable.

amount is often much lower than the price of health insurance, which even for the cheapest plan could exceed \$2,000 annually. Some with low-expected medical costs and high risk-tolerance may opt to pay the penalty and risk illness rather than buy insurance.

Indeed, the IRS reported that roughly 6.5 million taxpayers opted to pay the penalty rather than buy health insurance in 2015, and the average penalty amount was just \$470 (Koskinen 2017). Furthermore, Diamond et al. (2018) show that buyers could be even more strategic in their timing. A sizable share of customers appear to enroll in insurance, quickly obtain any health care they need, and then drop insurance after a month (while paying the penalty). Insurers are powerless to stop these purchasers due to the guaranteed-issue rules discussed above.

As part of the 2017 tax law, Congress reduced the penalty amount to zero starting in 2019, effectively dismantling this particular leg of the ACA “stool”. The question arises how this may destabilize the overall ACA marketplaces. Later we discuss empirical evidence suggesting that the ACA reduced uninsurance mostly by making health insurance more affordable, and the individual mandate nudged only a small share of customers to buy insurance. If so, zeroing the penalty amount may not dramatically alter the marketplace. However, if the mandate was key in pooling healthy customers with the sick, then we may see premiums rise and an adverse selection death spiral result.

While the Trump administration has *de facto* repealed the individual mandate, the employer mandate remains. This other section of the ACA orders employers with more than 50 employees provide employer-sponsored health insurance. As we will see from Chapter 18, most Americans gain their insurance in pools sponsored by their employers.

Making health insurance more affordable

In 2016, the average annual premium for the Silver plans was \$4,583 before any government subsidies. The federal poverty level (FPL) that same year was \$11,770 for an individual.⁵ If the ACA had just enacted community rating and the individual mandate, it would be mandating that people living at the federal poverty level (and not eligible for Medicaid) pay almost 40% of their annual income for health insurance.

To reduce the regressiveness of the mandate, the ACA enacts provisions to make health insurance more affordable for the low-income. First, eligibility rules for Medicaid are expanded to accept more low-income enrollees. Secondly, for those still not eligible for Medicaid, the government offers subsidies on an income-based sliding scale to cover both out-of-pocket premium and copay costs.

Medicaid expansion

Unlike Medicare, which is operated by the federal government, Medicaid is run and largely controlled by the states. Before the ACA, the federal government only required states to offer Medicaid to poor pregnant women and children in families below the federal poverty level (FPL). Beyond this minimum, states decided their own rules. As a result, policies and eligibility could and did vary dramatically by state.

For example, before the ACA, Vermont offered the most generous insurance program and covered parents making up to 331% of the FPL and childless adults making up to

⁵ In 2016, the FPL was \$11,770 for an individual, \$15,930 for a household of two, and \$24,250 for a household of four.

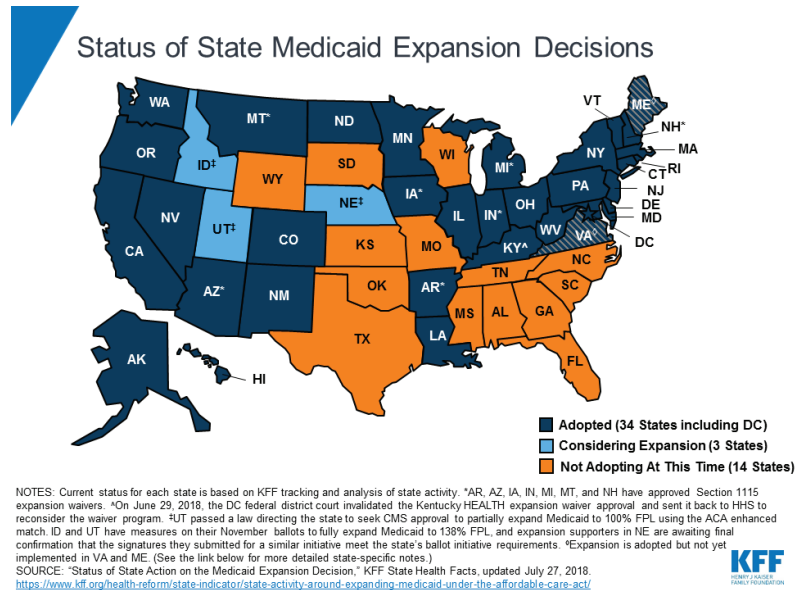


Figure 1.2. Medicaid expansion status by state as of August 2018 (Kaiser Family Foundation 2018).

the net effects are sicker pools and higher premiums for customers overall (Clemens 2015, Sen and DeLeire 2016).

Premium tax credits

For anyone not eligible for Medicaid, the ACA places an upper limit on the premium cost as a percentage of income. Table 1.3 lists the maximum premium at various income levels. For example, an individual with income at 200% of the FPL in 2016 (\$23,540) pays at most $6.3\% \times \$23,540 = \$1,483$ for his policy. The government then makes up the rest of the premium with tax credits. One feature of this design is that for the subsidy-eligible, their costs do not rise even if overall premiums do. Instead, the government (and individuals paying the full price) are exposed most to premium increases.

These premium tax credits reduce the initial cost of acquiring health insurance but not the subsequent costs of obtaining health care. Recall that Silver plans have a 70% actuarial value, so individuals still expect to pay 30% of their medical expenses out-of-pocket. To

Table 1.3.

Income Level	Maximum Out-of-pocket Premium Cost as a % of income
100 – 133% FPL	2%
133 – 150% FPL	3 – 4%
150 – 200% FPL	4 – 6.3%
200 – 250% FPL	6.3 – 8.05%
250 – 300% FPL	8.05 – 9.5%
300 – 400% FPL	9.5%

Source: Kaiser Family Foundation (2013a).

Table 1.4. *After-subsidy actuarial values of basic benefit plan for individuals purchasing Silver plans on the Health Insurance Marketplace by income level.*

Income Level	After-Subsidy Actuarial Value
100 – 150% FPL	94%
150 – 200% FPL	87%
200 – 250% FPL	73%
250 – 400% FPL	70%

Source: Kaiser Family Foundation (2013a).

alleviate this potential burden for the low-income, the ACA also subsidizes deductible and cost-sharing payments for those eligible. These subsidies were calculated to achieve the after-subsidy actuarial values listed in Table 1.4.⁶

Attracting insurers to the marketplace

All the provisions of the Affordable Care Act described thus far are designed either to attract customers to purchase insurance (tax credits and subsidies) or compel them (the individual mandate). These measures ensure demand for health insurance on the state exchanges, but what about the supply of health insurance? The ACA also enacts measures that reward or at least safeguard private insurers selling plans on the Health Insurance Exchanges.

Before discussing these measures, it is helpful to understand the new uncertainty insurers face. Prior to the ACA, the business model of insurers relied on predicting customers' risks and charging them accordingly. Higher-risk types were charged higher premiums than lower-risk types. Like experienced gamblers, the insurers knew they were inevitably going to lose money on some customers, but they also expected to win money on others. On average, they could expect to at least break even.

The ACA upended the old order of operations. Now to sell individual or small group insurance, an insurer posts a menu of insurance plans and prices, and customers who find the offerings agreeable buy plans. Under the ACA, insurers no longer have the opportunity to pre-screen the risks of their customers.

At first glance, the new order seems no different from how nearly all retailers operate. For example, a TV manufacturer posts a price and sells to anyone willing to pay that price. As long as price is greater than cost, the seller profits from each sale.

But health insurance is not like most retail, because costs are determined by who enrolls, and who enrolls is determined by the price. Insurers do not know their own costs until enrollment occurs (and really not until after risks are realized). As a result of the ACA, insurers face new uncertainty that they will suffer sizable losses if they overestimate the health of its potential customers.

⁶ The actual financing of these cost-sharing subsidies has generated significant political controversy. We return to this topic briefly in the conclusion.

This uncertainty was especially dramatic in the ACA's first years. After an initial adjustment period, insurers might have enough experience and data to reliably predict their costs for the next year. But during the transition period, insurers could only rely on educated guesses on enrollment to predict their potential costs.

Facing reluctant insurers, the designers of the ACA tried to reassure (and re-insure) firms. The ACA implements three measures, colloquially known as the 3Rs, all aimed at reducing the risk of offering plans on the new Health Insurance Exchanges:

- Reinsurance
- Risk Corridors
- Risk Adjustment

The Risk Adjustment program is the only one of the three programs designed to be permanent. Whereas reinsurance and risk corridors aimed to ease the transition to the ACA, risk adjustment has the permanent goal of disincentivizing insurers from “cream-skimming” by reducing the benefits of attracting healthy patients (the “cream”) and repelling sick ones. Under the risk adjustment program, insurers submit annual demographic and diagnosis information of its enrollees to the government, and the government calculates a risk score for insurer. Insurers with lower risk scores transfer money to insurers with sicker enrollees. If the transfers are calibrated correctly, risk adjustment removes the insurers' motivation to dodge sick customers (see Chapter 17).⁷

Reinsurance and risk corridors were both temporary 3-year programs ending in 2016 designed to onboard insurers to the new marketplaces. Reinsurance is insurance for insurers. Firms buy reinsurance from the government by paying a fee (i.e. premium) based on their number of enrollees. At the end of the year, the government disburses these funds to any insurers who enrolled very-costly customers. Similarly, risk corridors refunds any insurers who suffer negative losses (below 97% of a insurer-specific target). But to fund this compensation, the risk corridor program forces any insurers making large profits (above 103% of the same target) to return some of their profits. Both these two R's try to guard insurers from heavy losses due to an unexpectedly sick pool of customers.

All three programs were designed to be budget-neutral. Insurer contributions pay for reinsurance, and the risk adjustment program and risk corridors transfer money between insurers.

The effectiveness of the three R's lies entirely in the specifics. What factors should be included in the risk score calculation for risk adjustment? How much should the government charge for reinsurance? What are the right targets for insurers under the risk corridor programs?

In practice, the government generally overestimated the health of customers and so were short on the funds needed for transfers (Glied et al. 2015). The reinsurance program was able to make full payments in 2014, but in 2015, contributions to the reinsurance fund were \$6.5 billion, compared to \$14.3 billion in requests for payments (Cox et al. 2016).

Similarly, contributions to the risk corridor collection managed just \$0.36 billion compared to \$2.87 billion in claims in 2014. That year, the program paid only 12.6% of

⁷ On July 9 2018, the Trump administration announced it was suspending the risk adjustment program before reversing the decision on July 24. The risk adjustment program paid \$10.4 billion in 2017 (Mathews 2018).

requests. While some policymakers have subsequently tried to work with Congress to obtain more funding, opponents of the ACA there vehemently opposed additional support (Pear 2015).

As a result of the funding shortfalls, some insurers have shuttered, and some have filed lawsuits to recover the promised risk corridor payouts. These lawsuits, still unresolved, are one of many battles still facing the ACA.

Paying for the ACA

The ACA led to a huge expansion of Medicaid rolls and instituted subsidies to help millions of customers afford health insurance on the state-run exchanges. It also instituted reinsurance policies to help attract health insurers to the exchanges. These changes didn't come cheap. The Congressional Budget Office estimated that the coverage provisions alone cost the federal government \$110 billion in 2016 (Congressional Budget Office 2016).

To help pay for this expansion of care, the Affordable Care Act implemented novel cost control measures in Medicare and Medicaid and also imposed a series of new taxes (Kaiser Family Foundation 2013b). High-income taxpayers faced increased taxes on wages and unearned income. Medical devices and tanning salons were targeted with tax increases. Very high-value health insurance plans were also set to face a 40% tax—the so-called “Cadillac tax”—but implementation has been delayed.

1.2 Evidence on the ACA's Impact

The relative recency and various delays in the ACA's implementation mean researchers have only just begun to quantify its effects. Ironically, some of the delays and setbacks actually help researchers. For example, the Supreme Court's ruling that the states would not be required to expand Medicaid allows researchers to disentangle the impact of Medicaid expansion from the rest of the ACA.

Most of the empirical research on the ACA follows a strategy known as “difference-in-differences.” Researchers compare outcomes before and after the ACA, and also compare states or regions that were more or less affected by a change. Several studies compare states that expanded Medicaid to those that didn't, for example. Some compare areas with a large fraction of people eligible for subsidies with areas with fewer eligible. These multiple comparisons (and thus multiple differences) give this empirical strategy its name.

ACA's impact on uninsurance

Before the ACA, while the number of uninsured in America fluctuated some with the economic cycle, the uninsurance rate of the non-elderly had mostly stabilized between 16% and 18%. We focus here on non-elderly citizens, since those 65-years-old and above are eligible for Medicare and mostly unaffected by the ACA. In 2014, following the implementation of the ACA's major components, the uninsurance rate dropped to 13.3% and it fell further to 10.5% in 2015 (Figure 1.3). Compared to 2013, roughly 12.5 million more people had health insurance coverage. Medicaid enrollment increased by 15 million nationwide,

Uninsured Rate Among the Nonelderly Population, 1995-2015

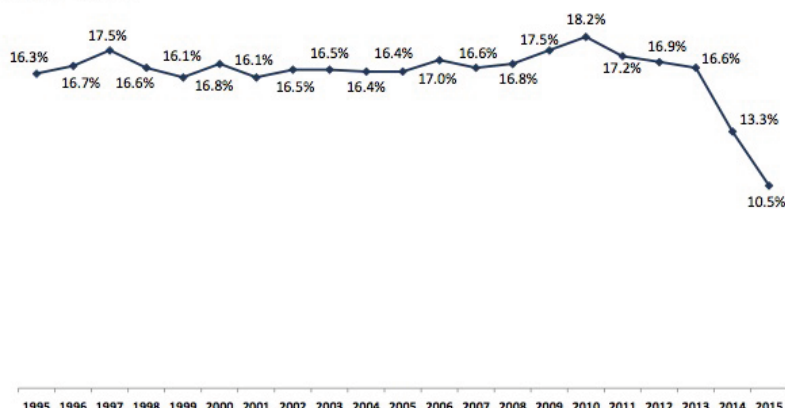


Figure 1.3. Percent of non-elderly US citizens and legal residents without health insurance by year (Kaiser Family Foundation 2016).

and 11 million people purchased their insurance through an ACA marketplace (Kaiser Family Foundation 2016).

Some researchers have tried to understand the relative contributions of different ACA components toward this expansion of coverage. Frean et al. (2017) attribute 60% of the drop in uninsurance to Medicaid expansion and the remainder to subsidies and regulations in the individual marketplace. The mandate itself did not significantly move people to obtain insurance, which may be unsurprising given the penalty's relatively small size.

The authors also find a strong “woodwork effect” of Medicaid expansions, as the publicity surrounding the ACA induced people who were already eligible before the change to “come out of the woodwork” and sign up.

Table 1.5 lists the source of insurance for those insured in 2015. The dominant source remains employers, and the fraction relying on employers for insurance is virtually unchanged from before the ACA (Long et al. 2016). This evidence seems to suggest that earlier worries that small firms would push employees to the individual marketplace did not play out, potentially due to other incentives embedded in the ACA to discourage firms from dropping their employer-sponsored plans.

Table 1.5. Sources of health insurance in 2015.

<i>Private</i>	Employer-based coverage	55.7%
	Direct purchase from exchange	16.3%
<i>Public</i>	Medicaid	19.6%
	Medicare	16.3%
	Military coverage	4.7%

Individuals may switch between insurance types during the year or maintain multiple insurance types at once. As a result, the percentages sum to greater than 100%.

Source: Barnett and Vornovitsky (2016).

Who remains uninsured?

Despite the uninsurance rate falling by about 6 percentage points after 2014, health insurance in America is still not universal. Over 28 million people did not have insurance in 2015. The composition of this uninsured group is meaningful both in terms of assessing the ACA's success and predicting the stability of the ACA's marketplaces.

Figure 1.4 shows the uninsurance rate in the U.S. by age. The rate first jumps at age 19 when government-sponsored insurance for poor children through the Children's Health Insurance Program (CHIP) ends. There appears to be another small increase at age 27, the age at which dependents can no longer remain on their parents' health insurance plans. After that, the uninsurance rate steadily declines until age 65 when Medicare eligibility begins. The introduction of the individual mandate in 2014 seems to have had little impact on this overall pattern.

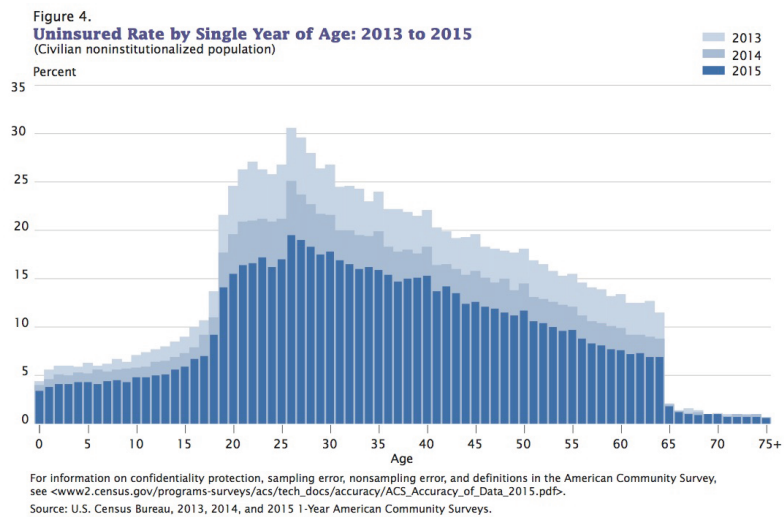


Figure 1.4. *Uninsurance by age* (Barnett and Vornovitsky 2016).

Thus young adults in their twenties and early thirties appear most willing to pay the mandate penalty and forgo health insurance. Adults at these ages also tend to be relatively healthy and have manageable health care costs, so the benefit of insurance is low. That this relatively healthy subgroup is forgoing insurance, however, implies that the individual mandate is unsuccessful at herding the healthy onto insurance plans. Risk pools are on average sicker and premiums higher than they would be under a stronger mandate.

ACA's impact on health outcomes

Courtemanche et al. (2017) examine self-assessed health and find no statistically significant impact overall as a result of the ACA. They do find some evidence of improved health among the older working-age population. Their result matches the finding from the Oregon Medicaid Experiment that improved access to health care mostly affects the health of the most vulnerable.

Reassuringly, Courtemanche et al. (2017) do not find evidence for increased *ex ante* moral hazard either. Risky behaviors—“smoking, drinking, and overeating”—did not

increase with broadened insurance coverage. As researchers collect more data in the coming years, they will be better able to assess whether the provisions of the ACA encouraging preventative care are having beneficial effects in the long run.

ACA's impact on financial outcomes

Researchers have also studied the ACA's effect on non-health outcomes. Boudreaux et al. (2017) show that total medical spending—premium plus out-of-pocket spending—for those receiving subsidies fell by \$811. In confirmation, Hu et al. (2016) find that gaining Medicaid reduced unpaid bills and debt by between \$600 and \$1,000. More insurance also implies less need for uncompensated care at hospitals, which Dranove et al. (2016) find to be true but only in Medicaid expansion states.

On the other hand, overall medical spending for families seems to have increased slightly during the same time period for other groups, potentially due to rising premiums (Boudreaux et al. 2017).

Lastly, Kaestner et al. (2015) find a small increase in labor supply after the ACA, contrary to the concern that additional welfare would disincentive people from working (Buchmueller et al. 2013).

1.3 Conclusion

Since its passage in 2010, the ACA has endured continual backlash and attempts at repeal. And yet, its popularity as measured in polls has risen in recent years. In 2013, 42% of the respondents reported believing that the federal government has a responsibility to ensure universal health coverage. By June 2017, that share had grown to 60% (Blendon and Benson 2017).

Nevertheless, the current administration is hostile, so the future of the ACA remains murky. Though the ACA survived repeated legislative efforts at a full repeal during Summer 2017, Congress later effectively dismantled the individual mandate by reducing the penalty for uninsurance to zero. In this chapter, we discussed how the mandate was designed to pool healthy and sick customers, but that even the original penalty amounts might have been too low to deter adverse selection. Thus the consequences of zeroing the penalty on enrollment and on premiums is still unknown.

The ACA has other battles up ahead too. Due to an oversight by the original lawmakers, the government may not be able to pay the cost-sharing subsidies used to reduce out-of-pocket expenses for the low-income. During the legislating process, writers of the ACA neglected to specify the pool of money meant to pay for these subsidies. In legal language, they failed to appropriate the funds.

This seemingly-small technicality may have drastic real consequences. The ACA still requires that insurers charge low-income customers out-of-pocket costs below the thresholds listed in Table 1.4. But to make this policy work, the ACA pledged to subsidize insurers for these cost-sharing reductions (CSRs) by effectively paying copays and deductibles for the poor. The missing appropriation might mean the insurers do not receive subsidies, but are still forced to operate and price plans as though they were. If so, offering plans to low-income customers will almost certainly generate large losses. The Trump administration has decided not to pursue appropriating the funds, meaning insurers have to make

up any gap on their own (or exit the market altogether). The exact response by insurers remains to be seen.⁸

Despite or because of these remaining hurdles facing the ACA, some Democrats are spearheading further health care reforms. In Nevada, a bill that would enable all residents to purchase Medicaid coverage reached the governor's desk before being vetoed. Several Democratic Senators have sponsored a "Medicare-for-All" plan, which would move America to a single-payer health care system akin to Canada and the United Kingdom (see Chapter 16).

Hence neither Republicans or Democrats appear satisfied with the ACA being the last major health care reform in the United States. As more evidence about the ACA mounts, lawmakers may tweak it slightly or overhaul it altogether, perhaps toward the pre-2010 status quo or toward a single-payer system. Regardless, health care policy will remain for the foreseeable future a fertile area for policymaking, political debate, and economic research.

⁸ One likely response by insurers is increasing premiums to cover their potential losses. Since the government also subsidizes premiums with tax credits, the Congressional Budget Office estimates that the federal deficit may actually *increase* as a result of not funding the CSRs (Congressional Budget Office 2017).

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