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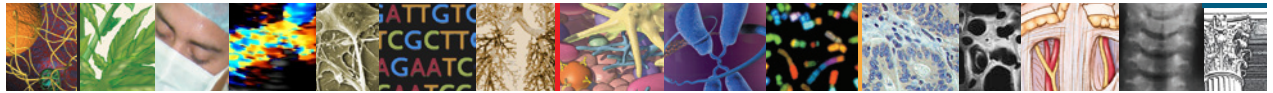
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Disentangling the ACA's Coverage Effects — Lessons for Policymakers

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Since the passage of the Affordable Care Act (ACA), an estimated 20 million Americans have gained health insurance, and the country's uninsured rate has dropped from 16% to 9% since

2010.¹ In the upcoming presidential election, the ACA's future is again at stake. Understanding how the law has achieved these coverage changes is critical to evaluating its progress.

The primary ACA tools that took effect in 2014 are by now familiar: the expansion of Medicaid (made optional for states by the Supreme Court in 2012), the availability of tax credits to help consumers purchase coverage on the new health insurance exchanges, and the implementation of an individual requirement to purchase health insurance or pay a tax penalty (the individual mandate). Since 2010, the ACA has also al-

lowed young adults to stay on their parents' health plan through 26 years of age. Multiple data sources and studies make clear that the uninsured rate has fallen dramatically since 2014; what is less clear is how these different pieces of the law have fit together to produce these changes.

We attempted to tease out the effects of the various provisions on insurance coverage (see table). Using data from the U.S. Census Bureau from 2012 through 2014, plus information on the law's provisions and premiums in health insurance exchanges throughout the country, we examined these provisions' effects by comparing

changes that affect various income groups and geographic areas. This approach takes advantage of the fact that people encounter different health insurance options depending on where they live (since Medicaid eligibility varies by state and premiums vary by rating areas within states) and what their family income is (which determines Medicaid eligibility, premium subsidies, and the mandate penalty). Our preliminary analysis identified several key results with policy implications.²

We find that the biggest factor in the coverage expansion in 2014 was Medicaid, which produced 63% of the gains we identified. This effect, however, actually comprised several distinct phenomena. Not surprisingly, the expansion of Medicaid eligibility to previously ineligible low-income adults played a key role. Overall, we estimate

Key Provisions of ACA Coverage Expansions Taking Effect in 2014.		
Provision and Policy Details	Policy Questions	Estimated Effects in 2014
Medicaid expansion		
Expanded eligibility to adults 19–64 yr of age with incomes below 138% of federal poverty level (FPL) — in states choosing to expand Streamlined application process and increased public awareness for adults and children eligible for Medicaid under pre-ACA standards	What percentage of newly eligible adults will sign up? Will enrollment among previously eligible adults and children also increase (“woodwork,” or “welcome mat,” effect)? Will Medicaid replace private insurance coverage for many beneficiaries?	44% of coverage gains due to enrollment of previously eligible adults and children, including the 2011–2013 early Medicaid expansions 19% of coverage gains due to enrollment of adults who became newly eligible in 2014 Enhanced enrollment in six early-expansion states No significant reduction in private coverage as a result of Medicaid expansion
Premium subsidies for exchange coverage		
Tax credits to subsidize the purchase of private insurance from state or federal health insurance exchanges Subsidy amount is tied to income and available to persons who aren't Medicaid-eligible and have income between 100% and 400% of FPL	How effective will premium subsidies be at inducing enrollment? Will participation vary with state policies regarding the exchanges?	37% of coverage gains due to premium subsidies Subsidies nearly twice as effective at increasing coverage in states with state insurance exchanges as in those using federal exchange
Individual mandate		
Individuals lacking health insurance must pay a tax penalty when filing federal income taxes In 2014, the penalty was equal to \$95 per person or 1% of taxable income, whichever was greater, but this increased to \$695 or 2.5% of taxable income by 2016 Some individuals are exempt because they have very low incomes, their state hasn't expanded Medicaid, they belong to a federally recognized Native American tribe, or they have no affordable coverage options	Will individuals and families be aware of the mandate details in a way that affects their insurance behavior? Will there be a more general effect of the mandate on insurance coverage rates? Will the effect of the mandate increase over time as the financial penalty for lacking coverage grows?	No significant effect of mandate details on coverage in 2014 A more general effect of the mandate to boost enrollment is still possible

that nearly one third of previously uninsured newly eligible adults in states that expanded Medicaid signed up for coverage in the expansion's first year, which accounted for 19% of the overall coverage change in our model. However, since only half of states chose to expand Medicaid by 2014, several million poor adults in the states that didn't expand Medicaid were left without viable coverage options.

Perhaps less obviously, we also found a substantial increase in Medicaid coverage among chil-

dren and adults who were already eligible for the program before 2014. This population accounted for 44% of the coverage increase. One component of this increase occurred in states that started the ACA's expansion process earlier than 2014. In six states, most notably California, the ACA Medicaid expansion took effect at least in part in 2012–2013. We find that these early efforts laid the groundwork for even larger gains in 2014, offering the first example of what will become a recurring theme: state implemen-

tation plays a key role in the ACA's effectiveness.

But even among people who were eligible for Medicaid under pre-ACA criteria, we found a large increase in coverage. That increase was made possible by the ACA's streamlining of the application process for Medicaid, removal of onerous asset tests for determining eligibility for most applicants, and increased public awareness about insurance coverage options. Moreover, expanding eligibility to the parents of children who were already eligible can help bring

coverage to entire families. We found evidence of this “woodwork,” or “welcome mat,” effect in all states, whether or not they expanded Medicaid. Meanwhile, another potential spillover effect of expanding Medicaid — the replacement of private coverage with public coverage (“crowd-out”) — did not occur. This finding suggests that the ACA’s Medicaid dollars have been effectively targeted to increasing coverage among people who would otherwise be uninsured.

While Medicaid accounted for roughly 60% of ACA coverage gains identified in 2014, the other nearly 40% was attributable to the law’s premium subsidies for coverage purchased on the new insurance exchanges. Our estimates suggest that for each additional 10% subsidy for the average family premium, nearly 1.5 million more Americans obtained health insurance. Though that gain is substantial in population terms, in economic terms it indicates that 2014 participation rates in the exchanges were more modest than originally projected. Participation will probably increase over time, however — a prediction that’s supported by exchange enrollment statistics from 2015–2016.

And there’s reason to think that state efforts can facilitate even greater participation. We found that premium subsidies were nearly twice as effective in getting people to enroll in coverage if they lived in states operating their own exchanges rather than in states participating in the federal exchange. This finding probably reflects multiple factors, such as more aggressive outreach and the creation of application-assistance programs in these

states, as well as political environments that are generally more supportive of the ACA.³

The law’s third key feature was the individual mandate. When we assessed the mandate’s detailed provisions, which include income-based penalties for lacking coverage and various specific exemptions from those penalties, we did not find that overall coverage rates responded to these aspects of the law. Does that mean the mandate had no effect? Not necessarily. If its primary result was to make all Americans more likely to obtain coverage — whether or not they were subject to the penalty and irrespective of how much it would cost them — our analysis would not capture that effect. Indeed, there is some evidence from analysis of a similar insurance mandate enacted in Massachusetts in 2006 to suggest that this phenomenon may explain part of the Medicaid woodwork effect⁴ and may also have induced some ambivalent consumers to purchase private coverage. Moreover, the dollar value of the mandate penalty was quite modest in 2014 (\$95 per person or 1% of taxable income, whichever was greater), but it increased substantially by 2016 (\$695 per person or 2.5% of taxable income). Thus, the mandate may play a larger role over time.

Finally, according to our analysis, the ACA’s effects on employer-sponsored insurance were essentially nil. Though some opponents have demonized the ACA as a “job killer” and a disrupter of health insurance for millions of people, our data and others’ analyses have shown no adverse effects on rates of employer-sponsored health insurance coverage, unemployment, or part-time work.⁵

As the country focuses on the 2016 election, we offer several key messages from our findings. State implementation continues to strongly affect the success — or shortcomings — of the ACA. This reality is most obvious in decisions about whether to expand Medicaid under the law, since the lack of expansion in 19 states has left roughly 3 million adults without coverage. But state policies also affect middle-income families’ ability to sign up for exchange coverage, which has been impaired in some states by legislative barriers to enrollment and lack of outreach. In essence, some state policymakers who rail against the ACA as a failed policy have created a self-fulfilling prophecy by taking steps to prevent people from signing up and benefiting from new coverage. Such actions may have contributed to the large gap between exchange enrollment rates in states participating in the federal exchange and those in states with their own exchanges. Though undermining coverage expansion may be politically expedient in some places, it is indefensible from a public health perspective.

With one presidential candidate pledging to build on the ACA and the other pledging to repeal it, and with state-level battles over the law ongoing, much is at stake in this year’s election. Overall, our results reveal several ACA provisions working effectively to expand health insurance coverage to millions of Americans. Whether the law continues to expand coverage in the future most likely hinges on the outcome of the November election.

Disclosure forms provided by the authors are available at nejm.org.

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Data Sharing — Is the Juice Worth the Squeeze?

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The past few years have seen considerable interest in the sharing of patient-level data from clinical trials. There is a clear and logical “ethical and scientific imperative”¹ for doing so, to permit activities ranging from verification of the original analysis to testing of new hypotheses. This interest has resulted in many publications and meetings, attention from the Institute of Medicine,² proposed changes in journals’ policies,³ and enormous effort from pharmaceutical sponsors and other groups to provide access to patient-level data.⁴ It is critical that we learn from these early experiences as we move forward.

Beginning in May 2013, GlaxoSmithKline made available to investigators the patient-level data and study documents from more than 200 trials that had started since January 1, 2007; the later addition of others resulted in access to data from more than 1500 trials sponsored by GlaxoSmithKline, including all their global intervention trials since the formation of GlaxoSmithKline in 2000. Beginning in January 2014, re-

quests for data could be made through a public website, clinicalstudydatarequest.com (CSDR), and were subject to approval by an independent review panel.⁴ Other trial sponsors joined CSDR.

In March 2015, the Wellcome Trust took over running the independent review panel for CSDR. In an attempt to increase participation even further, a small number of sponsors were given the right to veto data requests for commercial reasons, although such vetoes were strongly discouraged. Wellcome recruited a new panel, which started reviewing proposals in December 2015. As the members of the original independent review panel, we can report on the first 2 years of applications for access to data and on the results of a brief survey about project status that was sent to the lead investigators of all approved protocols, as well as a survey of sponsors about publications of which they were aware. At the time, data from 3049 trials were available through the website, from Astellas, Bayer, Boehringer Ingelheim, Daiichi Sankyo, Eisai, GlaxoSmithKline, Lilly, Novartis,

Roche, Sanofi, Takeda, UCB, and ViiV Healthcare.

Overall, 177 research proposals were submitted between May 7, 2013, and November 14, 2015. The panel had 30 working days within which to complete their reviews; all reviews were completed before December 31, 2015. Access was granted for 144 of these proposals; 33 were withdrawn after the panel requested additional details, and in all but 6 of those cases a new proposal was submitted because data from additional studies were needed. In 58 cases, the panel required the requesters to improve their lay summary. These 177 proposals included requests for data from 237 studies not yet in the system; access was granted to data from 179 of these. The commercial veto option was never exercised.

Most proposals (148) were for a new study and publication, with confirmation of original studies’ results (3) being quite uncommon. Statistical methods ranged widely and included predictive models (63), meta-analysis (28), survival analysis (15), and tests of new analysis methods (14). The most