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## Insurance Coverage and Access to Care Under the Affordable Care Act

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## Insurance Coverage and Access to Care Under the Affordable Care Act

### Abstract

SUMMARY: This brief details changes in insurance coverage and access to care under the Affordable Care Act. About 20 million individuals gained coverage under the law and access to care improved. Despite these gains, more than 27 million individuals are still uninsured, and many others face barriers in accessing care. As a result of the 2016 elections, the future of the ACA is uncertain. As the next Administration and policymakers debate further health system reforms, they should consider the scope of the ACA's effects on their constituents.

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## SUMMARY

This brief details changes in insurance coverage and access to care under the Affordable Care Act. About 20 million individuals gained coverage under the law and access to care improved. Despite these gains, more than 27 million individuals are still uninsured, and many others face barriers in accessing care. As a result of the 2016 elections, the future of the ACA is uncertain. As the next Administration and policymakers debate further health system reforms, they should consider the scope of the ACA's effects on their constituents.

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## ACA Impact Series

# INSURANCE COVERAGE AND ACCESS TO CARE UNDER THE AFFORDABLE CARE ACT

Stacey McMorrow, PhD

Daniel Polsky, PhD

The 2010 Patient Protection and Affordable Care Act (ACA) was designed to reduce the number of uninsured Americans and ultimately improve access to health care services and population health. Nearly three years after the major coverage provisions took effect, this brief assesses the ACA's impact on coverage and access to care through mid-2016. It also considers remaining barriers to coverage and care under the law as well as the implications of repealing some or all of the ACA's major provisions. Finally, it recommends research and policy priorities going forward.

## KEY ACA PROVISIONS

The ACA expanded coverage through two key mechanisms: Medicaid expansion for those with the lowest incomes, and federal subsidies to purchase private coverage in new health insurance Marketplaces for those with moderate incomes. In addition, the law required private insurers to allow young adults to remain on a parent's plan until their 26th birthday. The ACA also included several insurance market reforms to ensure that individuals could get comprehensive insurance regardless of their health status, as well as a requirement that individuals obtain insurance or pay a penalty.

The law included provisions aimed at improving access to care for key services and special populations. Longstanding concerns about provider participation in Medicaid and large expected increases in enrollees led to the inclusion of a temporary increase in the Medicaid reimbursement rate to primary care providers. Community health centers received additional funding to ensure that those gaining coverage in medically underserved areas would have some place to seek care and to maintain the safety net for those without coverage. The ACA also emphasized the importance of preventive care by requiring coverage for a selected set of recommended screenings and immunizations without cost-sharing, with a subset of these services specific to women, including all FDA-approved methods of contraception.

## TIMELINE

The expansion of dependent coverage to young adults and the preventive service requirements for private insurers were implemented in late 2010, with the women's health service requirements following in August 2012. In addition, several states chose to expand Medicaid to childless adults before the required January 2014 start date. These states included California, Connecticut, DC, Minnesota, New Jersey and Washington, and while the states received a federal match for these

THE YOUNG ADULT PROVISION, MEDICAID EXPANSION AND MARKETPLACE SUBSIDIES PLAYED AN IMPORTANT ROLE IN COVERING THE UNINSURED.

early expansions, they did not receive the ACA-enhanced match until 2014. Before the 2014 Medicaid and Marketplace expansions, however, the Supreme Court ruled that requiring states to expand Medicaid under the ACA was not constitutional and thereby left the decision up to states on whether to participate.

Ultimately, 24 states and DC expanded Medicaid in January 2014 with seven states following by the end of 2016. Several states received federal waivers to expand in alternative ways. The first was Arkansas, which uses Medicaid funding to purchase private insurance for eligible individuals in the federal health insurance Marketplace. Other states with waivers include Iowa, Indiana, Michigan, Montana and New Hampshire. Pennsylvania received a waiver, but transitioned to a traditional expansion shortly after implementation. Like Arkansas, New Hampshire is using Medicaid funds to purchase coverage in the Marketplace. The other waiver states are requiring eligible individuals to pay premiums or copayments above statutory limits, providing healthy behavior incentives, eliminating transportation benefits, and waiving retroactive eligibility in various combinations.

In addition to the Supreme Court decision, there have been a number of delays and deviations from the law's intended implementation structure and timeline. Nevertheless, despite a rocky start for Healthcare.gov and several state-based exchange websites, millions of individuals have gained access to affordable coverage under the ACA. Given the outcome of the 2016 presidential and Congressional elections, however, the future of the ACA is now in question. Proposals to repeal and replace the law provide few specifics, but significant changes to key coverage provisions seem likely.

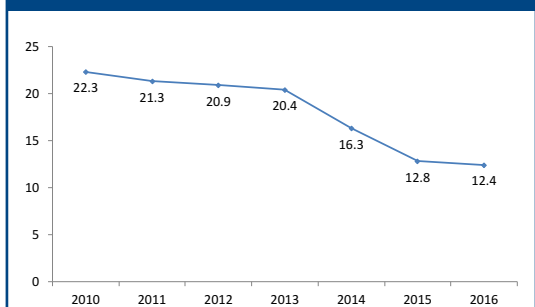
KEY FINDINGS ON COVERAGE AND ACCESS

Coverage

**Overall.** The [Gallup-Healthways Well-Being Index](#), the [Health Reform Monitoring Survey](#) (HRMS), the [National Health Interview Survey](#) (NHIS), and others have found steady declines in the uninsured rate between late 2013 and mid-2016.<sup>1-3</sup> The most recent NHIS data show that the uninsurance rate among nonelderly adults in the US has dropped from more than 20% in 2010 to 12.4% in 2016. See Figure 1. This translates to about [20 million fewer uninsured](#) individuals in the first six months of 2016, compared to 2010.<sup>4</sup> While it is difficult to attribute all of these coverage gains to the ACA, the evidence suggests that the expansion to young adults, the Medicaid expansion and subsidies to purchase Marketplace coverage each played an important role in covering the uninsured. Importantly, [employer-sponsored coverage](#) remained relatively stable over this period.<sup>5</sup>

**Young Adults.** The 2010 dependent coverage expansion reduced the number of uninsured young adults substantially between late 2010 and 2012.<sup>6,7</sup> Among young adults, stronger coverage gains under the dependent coverage provision were found among [higher income](#) and [white adults](#), presumably due to a higher likelihood of having parents with employer coverage.<sup>8,9</sup> Larger gains were also found among young adult men, but no differences in coverage gains were found by [disability status](#) or [urban residence](#).<sup>10,11</sup> An estimated [two million young adults](#) gained coverage through the dependent coverage provision from 2010 to 2013.<sup>12</sup>

Figure 1  
Percent Uninsured Among Nonelderly Adults (18-64), 2010-2016



Source: National Health Interview Survey, 2016 is January-June. Zammitti E, Cohen R, Martinez M. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016. National Center for Health Statistics; 2016 Nov. Available from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf>

VARIOUS SURVEYS FOUND IMPROVEMENTS IN SELF-REPORTED ACCESS AND AFFORDABILITY OF CARE, WITH MORE PRONOUNCED EFFECTS IN MEDICAID EXPANSION STATES.

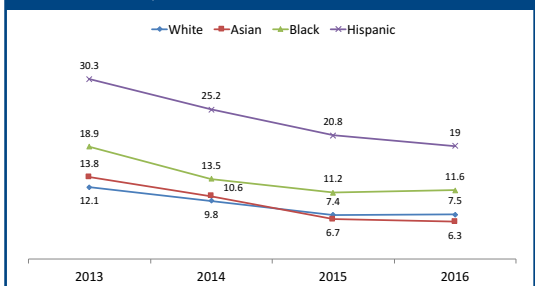
**Medicaid expansion.** Between 2010 and 2013, early Medicaid expansions reduced uninsurance in [California](#) and [Connecticut](#), while coverage gains in DC were modest because the early expansion largely shifted enrollees to Medicaid from an existing state-funded program.<sup>13,14</sup>

A variety of [studies](#) indicate that the 2014 ACA Medicaid expansions increased Medicaid coverage and reduced uninsurance.<sup>15</sup> The strongest studies have confirmed large gains in Medicaid and declines in uninsured through 2014 and into 2015, though the results on crowd-out of private insurance are less consistent across studies.<sup>16-21</sup> [Surveys](#) show continued coverage gains in expansion states throughout 2015 and into 2016.<sup>4</sup> In addition, two studies examining expansions in [Arkansas and Kentucky](#), have found that both the premium assistance model in Arkansas and the traditional expansion in Kentucky produced significant coverage gains compared to no expansion in Texas.<sup>22,23</sup>

**The Marketplace, insurance reforms, and other provisions.** Evidence of the impact of other ACA coverage provisions, such as Marketplace subsidies and the individual mandate, is more limited. Two studies have tried to disentangle the effects of the Medicaid expansion from the other ACA provisions and found that the Marketplace and other reforms were responsible for about [40-50% of the ACA coverage gains](#) in 2014.<sup>17,18</sup> Descriptive evidence continues to show coverage gains in the income bracket eligible for Marketplace subsidies, and administrative data found strong growth in Marketplace enrollment in [2015](#), and sustained enrollment in [2016](#).<sup>24,25</sup> As of March 2016, 11.1 million people were enrolled in Marketplace plans. [Evidence](#) also suggests that Marketplace coverage gains were larger in states that did not expand Medicaid, with more lower-income adults enrolled in the Marketplace in those states.<sup>26</sup>

**Racial and Ethnic Coverage Disparities.** The [NHIS](#) found significant increases in coverage among all racial and ethnic groups, as shown in Figure 2.<sup>4</sup> Additional studies have found significant reductions in coverage disparities for black and Hispanic adults, although disparities remain.<sup>27-29</sup>

**Figure 2**  
Percent Uninsured Among Nonelderly Population by Race and Ethnicity, 2010-2016



*Source:* National Health Interview Survey, 2016 is January-June. Zammitti E, Cohen R, Martinez M. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2016. National Center for Health Statistics; 2016 Nov. Available from: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf>

**Access**

Various [surveys](#) have found improvements in self-reported access and affordability of care since 2014, with more pronounced effects in Medicaid expansion states.<sup>30, 31</sup> Such studies have also examined access and [affordability](#) for various subgroups categorized by age, [sex](#), race/ethnicity, income, [parental status](#), and health status.<sup>32-34</sup>

**Young adults.** For young adults, a wealth of evidence finds that the ACA dependent coverage expansions increased [access to care](#), [utilization](#) of a wide variety of [services](#), and [reduced out-of-pocket spending](#).<sup>35-38</sup>

**Medicaid expansion and Marketplace coverage.** Several studies have found that Medicaid expansion was associated with improvements in having a personal physician or [usual source of care](#) and easy access to medicine;<sup>20,21,39</sup> increased visits to general doctors, overnight hospital stays, and cholesterol and diabetes diagnoses;<sup>16</sup> [increased prescription use](#);<sup>40</sup> more visits to [community health centers](#),<sup>41</sup> and [reduced OOP spending](#).<sup>42</sup> These studies are generally limited to access measures reported in 2014 and early 2015 and thus reflect relatively early evidence on access changes under the ACA.

WE FIND STRONG EVIDENCE OF GROWTH IN COVERAGE AND IMPROVEMENTS IN ACCESS AND SERVICE USE. HOWEVER, MANY GAPS IN COVERAGE REMAIN AND BARRIERS TO CARE PERSIST.

Different approaches to Medicaid expansion seemed to result in similar changes in access and use based on comparisons of expansions in Arkansas and Kentucky,<sup>23</sup> but additional [evidence](#) suggests that appointment availability was better for those with private option coverage in Arkansas compared to those who remained covered by traditional Medicaid.<sup>43</sup>

Coverage gains through the Marketplace have also been associated with improvements in access to a usual source of care, receipt of an [annual checkup and blood pressure screening](#),<sup>39</sup> and Marketplace enrollees experienced [gains in affordability](#) of care in 2015 as their continuity of coverage improved.<sup>26</sup>

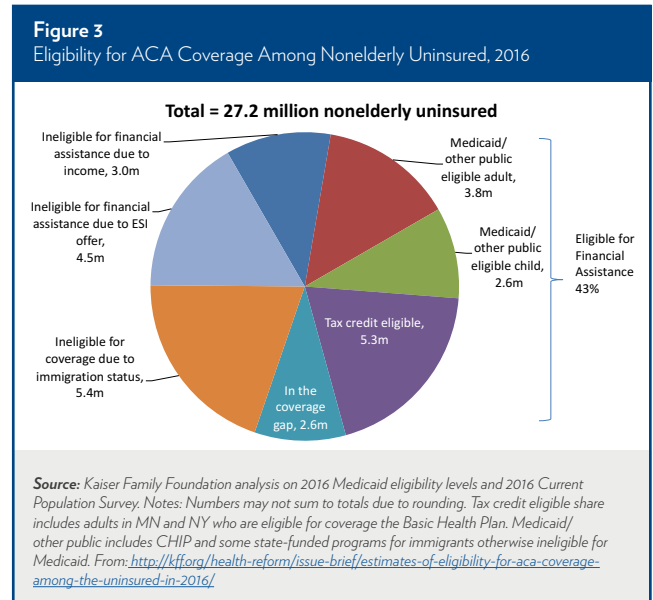
**Other provisions.** Only a few studies have examined the effects on access of provisions other than the major coverage expansions. One [study](#) in 10 states found an increase in appointment availability as a result of the Medicaid primary care fee bump,<sup>44</sup> and another study found reduced out of pocket spending on [contraception](#) following the requirement that private insurers cover these services without cost-sharing.<sup>45</sup>

### WHERE ARE WE NOW?

Consistent with other recent [reviews](#),<sup>46,47</sup> we find strong evidence of growth in coverage and improvements in access and service use through mid-2016. However, many gaps in coverage remain and barriers to care persist.

As of March 2016, an estimated [27.2 million](#) nonelderly individuals remained uninsured.<sup>48</sup> See Figure 3. About 43% were likely eligible for Medicaid or Marketplace subsidies. About 10% of the remaining uninsured fell into the coverage gap in states that did not expand Medicaid under the ACA, while another 17% were ineligible for Marketplace subsidies due to the presence of an affordable ESI offer. About 11% of the uninsured had incomes too high to be eligible for any financial assistance, and roughly 20% of the remaining uninsured were undocumented immigrants. [Uninsurance rates](#) were highest among Hispanics, those with low incomes and education, and those living in the South.<sup>49</sup> The most commonly reported reason for not having insurance is the cost of coverage,<sup>50</sup> but many uninsured are also unaware of the ACA coverage options and have [low health insurance literacy](#).<sup>51,52</sup>

The remaining uninsured are likely to face continued barriers to access and service use. But access and affordability problems persist even for many individuals with coverage. [Gallup estimates](#) for Q1 2016 find that 15.5% of adults reported not having enough money to pay for health care at some point in the past year, (42% of uninsured adults and 12% of insured adults).<sup>53</sup> [HRMS estimates](#) from late 2015 found that among adults with incomes below 400% of poverty, 28% of those without coverage reported problems paying



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THE RESEARCH DESCRIBED  
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family medical bills, compared to 16% for those with Medicaid and about 25% for those with ESI and Marketplace coverage.<sup>54</sup> Moreover, about 46% of Marketplace enrollees reported a deductible of \$1,500 or more, compared to 33% of adults with ESI. High deductibles and cost-sharing can contribute to the uninsured problem because people may not see the value in obtaining insurance, and to access problems because obtaining care can create financial burdens for some insured individuals.

Further access problems can arise if insured individuals face narrow provider networks that create barriers to needed care. One [study](#) found that, in 10 states, 60% or more of the networks in Marketplace plans were considered narrow, while in another 9 states, 40-60% of networks were narrow.<sup>55</sup> While narrow networks are not limited to Marketplace plans, in late 2015, about 14% of Marketplace enrollees on the [HRMS](#) reported being at least somewhat dissatisfied with their choice of providers, compared to 5% of adults with ESI.<sup>54</sup> Access to providers can also prove problematic for Medicaid enrollees. In late 2015, 19% of Medicaid enrollees reported trouble getting a doctor's appointment in the past year, a rate higher than adults with any other type of coverage. This reflects longstanding concerns about provider participation in the Medicaid program.

## RESEARCH AND POLICY PRIORITIES

Prior to the 2016 election, much of the focus in health policy circles was on improving the ACA to build upon its early successes, including efforts to enhance outreach to the uninsured who were eligible for Medicaid or Marketplace subsidies and to stabilize the Marketplace in the face of rising premiums. For researchers, there was an emphasis on providing evidence to inform states still considering Medicaid expansion, including information on enrollment for newly versus previously eligible adults and the implications for state budgets. Moreover, researchers were beginning to focus on more nuanced issues such as [churning](#) between Medicaid and Marketplace coverage to inform efforts to improve continuity of coverage.<sup>56</sup>

The uncertainty surrounding the future of the ACA has now shifted the conversation to the consequences of repealing the law's key coverage expansions. Estimates by the [Congressional Budget Office](#) and the [Urban Institute](#) project that a complete repeal of the ACA would reduce insurance coverage by 24 million by 2021.<sup>57,58</sup> Furthermore, the research described here provides considerable evidence on the consequences of repealing the Medicaid and Marketplace expansions for coverage and access to care. If the literature that has evolved based on the dependent coverage expansion is any indication, we should expect to see a wealth of studies over the next several years on the effects of the Medicaid expansion across subgroups and on a wide variety of access, service use and health status measures. It will be important, however, for researchers to further explore the impacts of the law on vulnerable subgroups as well as its impacts on downstream effects such as financial security, physical and mental health, labor market outcomes, and state budgets. Such evidence will reinforce the potential implications of changes to the law.

Additional research on specific state policy and implementation strategies, especially the effects of various waiver programs, will be particularly important if states are given more flexibility under the new administration. Moreover, any modification or replacement of the ACA will likely need to grapple with the issues currently facing the health insurance Marketplaces. The difficulty of providing universal and affordable access to coverage for individuals regardless of their health status has been made clear as insurers continued to exit the health insurance Marketplaces and premiums rose an average of nearly 25% in the fourth open enrollment period. Research is needed to consider how changes in the size and structure of subsidies, mandate penalties, rating restrictions and other factors could affect the stability of the individual market.

## ABOUT LDI

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With high and rising health spending likely to be a focus of the next administration, it will be important to investigate affordability problems for insured individuals associated with high deductibles and cost-sharing, which may reveal broader problems with these crude cost containment measures. One recent [study](#) has shown that these mechanisms do not result in more price-shopping by consumers, but do reduce the quantity of both high and low-value care received.<sup>59</sup> This suggests the need for more nuanced value-based insurance design as well as supply-side mechanisms to rein in health care costs. The strategy of narrow networks can be useful in containing costs, but their transparency and adequacy must be evaluated and ensured. As we consider the uncertain future of the ACA, we must continue to provide robust evidence to inform policymakers as they make critical decisions that will affect the health and economic well-being of millions of Americans.

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