Op-Ed

Meeting the ACA's Goals

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WHETHER AND TO WHAT EXTENT THE AFFORDABLE CARE ACT is meeting its goals continues to be debated, especially in this election season. Here's my take on these questions. The ACA has (at least) 3 major goals: (1) expanding coverage (and "reforming" the individual insurance market), (2) slowing health care spending and keeping it at a sustainable rate, and (3) improving clinical quality.

The jury is still out on the second and third goals. Health care spending has been growing at or near historically slow rates—4% before 2014 and 5.5% expected for 2014.¹ However, because 2015 is the first year of what appears to be a more robust recovery, it will take 2 to 3 years to assess what happened to health care spending when the economy has fully recovered from the deep and lingering recession of 2008-2009. Strategies to improve quality and to develop quality metrics are a part of the move to value-based purchasing and will also become clearer toward the end of the decade as these programs are fully implemented and mature.

What is more clear is that progress has been made toward expanding coverage and providing more certainty about the availability of insurance for those in the nongroup markets. While a lot of questions cannot yet be answered about how many previously insured people received coverage through the exchanges, the numbers and characteristics of previously uninsured people who received coverage in the exchanges, the type of insurance they now have, or how many of the previously uninsurable population has been covered, there is little doubt that the number of uninsured has been significantly reduced since late 2013.

One of the challenges of accurately tracking these trends has been the number of nonfederal surveys that have started reporting estimates of the uninsured in addition to the traditional federal surveys on insurance coverage, which include the National Health Interview Survey (NHIS), the Current Population Survey (CPS), and the Medical Expenditure

Panel Survey (MEPS). The newer nonfederal surveys are sponsored by the Commonwealth Fund, Enroll America, the Kaiser Family Foundation, the Gallup-Healthways Well-Being Index, the RAND Corporation, and the Urban Institute.² Two of the concerns that have been raised are that (1) these newer surveys rely on a mix of telephone surveys and web-based surveys, which is a strategy frequently used for public opinion surveys but less often for fact-based surveys, and (2) many of the new surveys have had low response rates—in the range of 5% to 10%—as opposed to federal surveys, whose response rates typically exceed 80%.

Nonfederal surveys have been used because of the strong interest in understanding the changes produced by the ACA as quickly as possible and sooner than the federal surveys have typically made data available. The problem is that faster is not always better and is frequently worse when it comes to data collection.

The challenges associated with multiple estimates of the uninsured are not new and have been a problem even with the various federal surveys.³ Tracking data on the uninsured over time has become even more challenging because of a change that the Census Bureau made in 2013 to the questionnaire used in its annual CPS. The questions on insurance coverage and the uninsured changed from whether respondents had coverage at any time during the past year to more detailed questions about the respondents' past insurance coverage. This change was meant to correct a long-perceived problem with the question's structure, which seemed to produce answers to a question other than that being asked. The timing of this change is unfortunate, however, and will likely make it difficult to use CPS data to track longer-term trends in changes in overall insurance coverage, type of insurance, and lack of insurance.

As has been widely reported by both the Obama administration and the media, another federal survey, the NHIS, reported in late summer its findings regarding health insurance coverage as part of an early release program. The NHIS found that 7 million fewer people were uninsured in the first quarter of 2015, compared with the average number of uninsured in 2014, and the number in 2014 followed a reduction of 8.8 million from the number of uninsured in 2013.⁴ These reductions produced an uninsured rate as of the first quarter 2015 of 9.2%, compared with a high of 16% in 2010 (and 14.2% in 2005, before the recession).

While the ACA has certainly helped reduce the number of the uninsured through subsidized insurance in the exchanges and the expansion

of Medicaid—which is hardly surprising for legislation that is expected to spend \$1.2 trillion in its first 10 years—it is not the only contributor. The improving economy is also a factor in the reduction.

With the data currently available, figuring out how much each (the ACA and the economy) has contributed is very difficult. According to data from the NHIS early release program, the number of people with private insurance at the end of the first quarter of 2015 who received insurance through the exchange increased by 3 million (up from 6.7 million) compared to the first half of 2014. Approximately 9.5 million to 10 million people received private coverage from other sources, presumably employer-sponsored insurance, a reminder that it is still important as a source of coverage growth. The RAND survey suggests that about 6 million more people were on Medicaid.⁵ There are more additions to coverage than there are reductions in the uninsured because some of those who bought insurance through the exchanges or received coverage from Medicaid had previously been insured. Other people signed up for insurance through the exchanges but then dropped their coverage later in the year or failed to pay their premiums after signing up, which complicates the estimates even more, depending on when during the year they were calculated.

The data from the other federal surveys, especially the MEPS survey, will not only provide an additional source of information about the uninsured but more importantly, will enable us to link the data on insurance coverage with health status as well as health use and expenditures. Past experience suggests that these other federal surveys are likely to produce somewhat different estimates of what has happened to the uninsured population. While this is frustrating for journalists and the public in general, it reflects the reality that different sampling techniques and different questionnaires can produce different population estimates.

The US Department of Health and Human Services has a mechanism that could help the public better understand the differences found in the federal surveys: the data council in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) exists precisely for this purpose. Even though it has rarely been used, it or some other mechanism needs to be activated to help the public understand all these different estimates and which data sources are likely to be the most reliable for which purposes. Of course, the data council will be of value only if the material that it produces is regarded as credible and nonpartisan. Whether this can happen in an election season is another matter.

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