Why repeal and replacement of the Affordable Care Act would have minimal impact, if it occurs at all

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Abstract While this author knows little about the inner workings of the legislative process, 25 years in the Revenue Cycle realm of the Hospital industry provided a great deal of education about how healthcare finance works. When managed healthcare (health maintenance organisations (HMOs) and preferred provider oraganisation (PPOs)) began to saturate the healthcare market with US$5 copays, a prediction was made that in 20 years or so, the country would devolve into indemnity-style coverage but with the rules and restrictions of the HMOs. Unfortunately this came true. As hospitals raised prices to offset contractual adjustment losses, insurance companies continually sought ways to manage costs and mitigate financial risk associated with claim payments. More recently, paying particular attention to the Affordable Care Act implementation and coupling with a historical view of healthcare and insurance cost structures led to the belief insurance costs would skyrocket. This too proved to be true without question. Having once been a proponent of totally eradicating this legislation, this author now believes some form of government intervention in the commercial healthcare market will remain and costs are unlikely to go down to any appreciable degree. There are many factors impacting the cost of healthcare and insurance to the consumer. This paper addresses three significant factors: the cost of care delivery, the cost of insurance and the impact of retaining facets of the Affordable Care Act in replacement legislation.

KEYWORDS: Affordable Care Act, ACA, insurance, healthcare, hospitals, costs

THE COST OF INSURANCE

Based on a review of relevant factors, the impact of the repeal and replacement of the Affordable Care Act (ACA) is likely to be much less consumer-friendly than promised and will make little difference for the cost of insurance in the future. The cost of doing business in healthcare and the cost of paying claims by insurance companies will remain fairly stable unless they continue to rise, because any efforts to repeal the current law fails to significantly address drivers

impacting health insurance premiums. The belief that the cost of care or insurance will go down, while keeping portions of the ACA that people will find losing unacceptable, creates a presumably immovable barrier to a full repeal. This paper summarises and explains a few of the reasons a true repeal and replacement with something that lowers costs is very unlikely.

Something most Americans will not hear from the media or politicians is that there are forces at work to keep many of the payment pathways put in place by the ACA. One of the biggest impacts is likely to be the lobbyists representing the hospital industry. According to a report in 2015 under the Affordable Care Act, hospital uncompensated care dropped by 21 per cent. This equates to US$7.4bn in new revenues compared to 2013.[1] Medicaid expansion states did better than non-expansion states, reducing uncompensated care by 1.7 and 1.0 per cent of operating costs, respectively.[2] Uncompensated care can be deducted from a business for tax benefits; however, a reduction in taxes is less favourable than an increase in cash payments. For example, a hospital would rather pay US$25 on US$100 in payments than zero dollars on zero payments. With this payment versus deduction scenario, the company still has US$75 more than if it had not been paid.

Hospitals rank fourth in over 400 industries for gross domestic product in 2015 with over US$800bn reported.[3] This figure represents hospitals that are separate from the more inclusive category of healthcare in total. There are approximately 5,400 hospitals operating in the United States today. As such, hospitals are likely to maintain a strong lobby presence in Washington DC. According to The Hill,[4] the American Hospital Association (AHA) spent over US$20m in both 2015 and 2016. The AHA ranked fourth among the top 50 lobbying groups, followed at fifth and sixth by Pharmaceutical and the American Medical Association lobbies, respectively.[5] These lobbyists and affiliated organisations will bring forth pressure to keep payment losses at a minimum.

One of the safeguards offered to insurance companies was the promise of 'risk corridor' payments to offset potential losses.[6,7] This was an enticement to build widespread commercial insurance company participation by filling the financial uncertainty gap for these payers. Note that insurance companies seek to mitigate risk and actively assess risk in the determination of premiums paid by consumers. The Affordable Care Act was the uncharted territory for expanding coverage for millions of Americans. Building a reliable foundation for such a massive change in a market economy required financial guarantees to offset risk to insurers. The risk concerns proved to be valid and insurance companies sought the risk corridor payments, only to discover that the risk corridor funding was inadequate to cover losses. Thus, far, multiple insurance companies have filed lawsuits against the Federal government to obtain the promised payments.[8] It is entirely plausible that recent premium increases were impacted by losses not paid as promised and the associated legal costs to seek payment.[9]

THE COST OF CARE DELIVERY

One might ask how hospitals would lose money if the Affordable Care Act goes away. With a full repeal of the ACA and its subsidies, hospitals will experience an increase in uncompensated care, with much of the loss tied to emergency room (ER) visits. ER visits will likely increase for two reasons. First, physician practices are less likely to accept uninsured patients into their practices and free clinics often have long waits. Second, the Emergency Medical Treatment and Active Labor Act (EMTALA . . . pronounced Em-Tal-Ah) requires hospitals to provide a medical screening and stabilisation to anyone who presents to their ER before discussing

financial ability to pay.[10] Screening and stabilisation includes all tests necessary to determine whether an emergent medical condition exists. By the time, the screening and stabilisation occurs, most of the cost of care has been incurred in diagnostic tests, nursing and physician time. It is commonly known in the healthcare industry that the ER is the highest cost option for outpatient treatment, but sometimes the only option for uninsured and very sick patients. For these reasons, the hospital industry and associated lobbies will fight hard to keep payments coming in from any viable source.

Political and media reports also indicate that a repeal of the ACA can reduce the cost of care. This is another media-political fallacy, at least with regard to hospital services. It may reduce the cost for treating uninsured patients in physician offices because many uninsured patients will not be accepted by practices. For hospitals, however, the cost of care is largely stable in that it is unlikely to decrease. This is tied to the top two costs of hospital care, labour and supplies. Salaries, wages and benefits make up approximately 55 to 70 per cent of hospital budget costs.[11,12] The second largest cost is supplies, which will be used in relation to patient volume. Since hospitals struggle with managing staffing and with the sickest patients typically admitted through the emergency department, labour and supply costs will remain high with or without the ACA.

There are reasons for the high labour costs in hospitals. Unlike many professions, hospitals require college degrees and/or specialised certifications as minimal requirements for employment. One of the largest employee groups in hospitals is registered nurses (RNs). According to a KPMG[13] study, an average RN's annual all-in compensation was US$98,000 or US$45 per hour. This cost includes salary, benefits, overtime, shift differential and employer-paid taxes.[14] Base wages reported were approximately US$56,000 per year. Given that hospitals provide nursing care 24 hours a day throughout the year, it is easy to see how labour costs remain high. An ongoing nursing shortage creates an upward pressure on these costs. According to the National League of Nursing,[15] lack of capacity related to educators and clinical training opportunities impacted the ability of nursing programmes to expand and cover demand. As with any shortage of labour in demand, an upward pressure on wages occurs as employers compete for qualified employees.

While nursing employees make up a large portion of employees, hospitals require other specially trained employees to maintain operations. Pharmacists, specialised radiological and nuclear medicine employees, laboratory technicians, physical/speech/occupational therapists and cardiac laboratory staff list but a few of the disciplines required for a functional hospital facility. Adding in clerical and custodial employees required to maintain daily operations further adds to operating costs. Coupling the need for highly specialised training and education, with a shortage in qualified applicants to fill demand, results in the likelihood for higher costs of care.

Healthcare is one of the most regulated industries in America.[16] Research literature shows that in this industry payment issues are so complex that hospitals struggle to support themselves financially.[17,18] The cost of keeping up with regulations and maintaining records for compliance can be daunting on its own. Regulatory agencies, however, inspect hospitals for compliance and follow up on complaints, often requiring additional training, process changes and even financial levies for failure to follow strict guidelines. A study[19] of hospital CEOs reported that over 50 per cent of hospitals would lose money if they had to survive on patient revenues alone. This was directly related to shrinking payments and payment denials from insurance companies.

Another significant cost to hospitals is malpractice insurance and paying against medical malpractice claims. A *Becker's Hospital Review* article noted malpractice claims paid US$3.6bn in 2012.[20] This paper stated that there is a medical malpractice payout approximately once every 43 minutes.[21] With millions of moving parts and hundreds of employees tasked with the care and protection of patients, mistakes are an unfortunate reality. It is also a costly reality that must be factored into the cost of care.

Many in the public have concerns about the high cost of insurance and believe premiums may go down if the ACA is repealed or replaced with something better. Another view is that premiums can be controlled with a la carte coverage. These are false notions as replacements to the ACA will have little impact on the cost of care. If the cost of care remains high, how can premiums intended to offset claim payments go down? The likelihood is premiums may remain stable or actually increase from fewer policy buyers. Insurance companies pay for services performed by doctors and hospitals. Those people who will opt out of purchasing care may be those in poor health who cannot afford high premiums but also those who are healthy and will create low utilisation of health services. The cost of insurance premiums is tied to health claim payments as they offset premium income. If the pool of income shrinks without a greater cost reduction from claims, premiums have no course but to remain stable or increase. Premium costs are less linked to the additional minor services added under the act and more to the cost of services that were already covered before the ACA. Cancer, surgery, ER visits, mammograms, MRIs and an extensive list of other services have always been covered. The cost of insurance is about what the insurance has to pay. Traditionally covered services are not going away and the cost of care is going up . . . so too may premiums.

IMPACT OF RETAINING POPULAR INSURANCE BENEFITS FROM THE ACA

Certain facets enacted with the Affordable Care Act that impacted premiums are significant. First, the no-cap on coverage meant insurance benefits no longer maxed out. Insurance companies have to keep paying for catastrophically or chronically ill patients. Prior to the ACA, there was a financial ceiling to insurance companies' financial risk. Now, when a catastrophically or chronically ill patient exceeds out-of-pocket costs, insurance companies are bound to continue payments for all future claims. To an insurance company, this represents an unknown future dollar risk and will force insurers to pass that risk on in premium dollars.

Second, allowing sons and daughters to remain on parents' coverage until age 26 meant an additional five to eight years of coverage for the same premium. Before the ACA, a covered child lost insurance at 18 (or 21 if in college). This meant a reduction in claims cost for the insurance company and potential premium income if the young person obtained insurance either on their own or through employment. According to Healthcare.gov, eligible persons can obtain and stay on parent's family health insurance coverage until age 26.[22] The US government site states individuals can be covered under parent's family health insurance even if the individual marries, has or adopts a child, starts or leaves school, lives away from the parent's home, or even turns down the offer of employer-based insurance.[23] The extended coverage option appears to be widely popular and affordable option for those families with young adult children. The Department of Health and Human Services (HHS) estimated 1.2 million individuals between ages 19 and 25 would elect to stay on parent's coverage in 2011.[24] This estimate appears to have been fairly accurate as Health and Human Services reported 2.3 million stayed on parent's coverage until age 26 between 2010 and 2013, with

an additional 3.4 million estimated to stay on parent's coverage between 2013 and 2015.[25] HHS also reports approximately 30 per cent of individuals between 19 and 25 lack any health coverage. A young and healthy individual might presume an average health insurance premium of US$500 per month (US$6,000 per year). With a total of 5.7 million electing to remain on parent's coverage, this would result in a loss of almost US$24bn in annual premium dollars if 70 per cent of these individuals obtained health insurance coverage apart from the parent's plan. Insurance companies will undoubtedly seek to recoup these dollars through a combination of higher premiums, higher deductibles and government subsidies.

Third, the ACA pre-existing condition inclusion meant that all insured people must have equitable premiums regardless of existing health conditions.[26] Without the option to deny coverage or charge a higher premium to those likely to have higher utilisation (risk) of insurance, everyone's premiums were adjusted upward to absorb the risk. This facet of the ACA may remain with a replacement plan. The advent of the ACA, with its provisions related to premium equity, removing barriers for pre-existing conditions and financial subsidies to offset insured's costs, provided greater access to healthcare for more people.[27] Greater access can translate to greater utilisation of healthcare services, especially by those whose pre-existing conditions proved prohibitive in obtaining health insurance. Greater utilisation by patients with pre-existing health conditions would increase insurance claim payments, further diminishing the gap between premium income and claim costs.

Finally, it is not widely reported, but the ACA included a plan to make 'risk corridor' payments to insurance companies from the Federal government to offset losses until market prices stabilised.[28,29] The risk corridor payment fund has consistently run out of money and insurers have filed lawsuits against the government to recoup the billions of dollars promised and then denied.[30,31] The fight to receive the risk payments results in insurers incurring additional legal costs. So, too, are insurance costs likely to be impacted. An upward pressure on premium costs is especially likely if insurers perceive the probability of having to fight for government payments in the future as well. Loss of revenues is consistently reported as the main reason insurance companies are leaving the ACA marketplace.

Health insurance companies must seek approval from state insurance commissions to raise premium rates. To receive approval, companies must show good cause, such as financial losses, to raise premiums for insurance subscribers. Since the advent of the Affordable Care Act, insurance premiums have risen faster than wages in the United States.[32] This would indicate that insurance companies experienced significant financial risk since the implementation of the ACA. Insurance companies' primary costs are related to paying healthcare claims. Under the ACA, insurance companies must devote at least 80 per cent of premium dollars to pay claims. If claims exceed 80 per cent of premium dollars, the remaining payments must be paid from the 20 per cent allocated for administrative costs and profits. Many insurance companies have sought, and continue to seek, premium increases in double digit percentages, hoping to keep payments within the 80 per cent threshold.

Even if the replacement plan for the ACA applies downward pressure on insurance premiums, other factors will counter that pressure to keep premiums at or above current levels. The inability to deny coverage for pre-existing conditions will likely remain in place, keeping risk and premiums high unless artificially reduced by government subsidies. Such subsidies would merely be a cost distribution paid by tax revenues rather than an actual cost reduction for insurance coverage. Those likely to drop coverage are those who see the least need, such as younger policyholders, resulting in a loss of insurance

premium revenue. These were the premium dollars anticipated to help offset the risk associated with older and sicker insurance policy buyers. Prior to the ACA, when a young adult went to work, he or she often bought insurance through an employer group health plan. This afforded separate premium dollars to insurance companies. The ACA extended family coverage availability to age 26, diminishing this pool of potential revenue to cover the risk of health claims. The extended family coverage until age 26 is very popular and, if it remains, will continue to decrease potential premiums from the 21–26-year-old populace, forcing insurance companies to offset these losses with premium dollars. Third, insurance companies will seek to recover billions of dollars in losses from the ACA by keeping premiums high for a period of time. Insurance companies will likely work to curb potential future losses by retaining premium increases now in place.

The current legislation proposed by the US House of Representatives retains premium subsidies for several years. The difference is that the subsidies are directed to the states for distribution.[33] The House bill also retains the young adult coverage found in the Affordable Care Act that allows family members to remain covered until age 26. Neither of these provisions would apply downward pressure on health insurance premiums and would continue some level of taxpayer support for the act, if implemented as written.

With repeal and replace legislation already published, and under congressional review at the time of writing this paper, insurance companies are still asking for premium rate hikes for 2018.[34] Three states, Connecticut, Maryland and Virginia, have requested premium rate increases of 15 to 60 per cent as the insurance companies indicate that the market is still unstable.[35]

CONCLUSION

The drivers of high healthcare costs will not go away as long as the Affordable Care Act replacement plan retains elements that raise the market price floor for insurance coverage. Insurance premium increases are the natural response in a market to rising cost and loss of projected revenues inaccurately promised in the ACA. In addition, any legislation currently proposed fails to address these cost drivers to any significant degree. The costs of labour, regulations and legal risk continue to push the cost of care delivery higher.

The Affordable Care Act rang a bell; an act that cannot be undone. Now that a source of revenue exists to offset losses, hospitals and other organisations will vigorously fund the fight to keep a viable payment source even if it means higher taxes or higher insurance premiums for the populace. It will also be politically unpopular to enact legislation that may result in the loss of insurance coverage or higher a la carte costs for those who are the largest consumers of health services. Also, the American people will strongly oppose any efforts to remove the popular components provided in the ACA. Few legislators are willing to risk the Capitol capital by voting against some of the popular ACA elements. Politicians will consider this the 'third rail' of political danger once reserved for Medicare and Social Security. Finally, the insurance industry considers itself 'once-bitten' by the Affordable Care Act and will likely not acquiesce to a plan that forces them to keep premiums low based on promises of future payments from the government.

Whether the United States healthcare system would be better off if the Affordable Care Act had never been implemented is a topic for much speculation and debate. The US healthcare system was already on a collision course with some form of change with nearly unchecked rising costs. Also, it is not the purpose of this paper to promote a straight repeal of the Affordable Care Act. Predicting the broad implications of such an act is beyond the scope of the author's intent. Comparing the cost of healthcare

over time with corresponding wage earning capacity for Americans, some intervention on the behalf of consumers seems inevitable. Widespread concerns regarding the cost of care were certainly catalytic to the juggernaut known as the Affordable Care Act.

Unless the healthcare marketplace can make significant moves to bring costs in line with what consumers can afford, insurance companies will have no motive to manage premium costs. Given the drivers of the cost of delivery, however, this seems highly unlikely. The math is very simple. To get more in the insurance market, you must pay more. More coverage = increased cost; More risk = increased cost; Fewer premium sources = increased cost; Lower deductibles = increased cost.

A total repeal of the Affordable Care Act may slow or stop premium hikes for the near term; however, this also appears unlikely and would still leave the essential issue of insurance cost drivers unaddressed. Whether the Affordable Care Act was ultimately good or bad for America is a separate topic for discussion and unrelated to the information presented herein. Regardless of whether through direct premium payments or increased taxes, the American people will continue to bear the cost of higher insurance premiums resulting from the tenets of the Affordable Care Act retained in any replacement plan. It would be a tremendous surprise to see a turning back of the financial impact tide created by the Affordable Care Act. In addition, a repeal or repeal and replace of the ACA would be unable to reverse the previously existing conditions in the health industry that made this healthcare law seem necessary.

AUTHOR'S NOTE

The opinions expressed in this paper are the author's own and do not reflect the views of Conifer Health Solutions, or its subsidiaries.

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