Is Obamacare on life support? (with transcript)

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Hagana Kim: Welcome to Case in Point, produced by the University of Pennsylvania Law School in collaboration with Bloomberg Law. I'm your host, Hagana Kim. Today we'll be talking about the fate of the Affordable Care Act as we approach 2018. Here with us today is Allison Hoffman, a professor of law and a healthcare law and policy expert here at Penn. And joining us from Arlington Virginia is Victoria Pelham, a healthcare reporter with Bloomberg Law. Thank you both for joining us. Victoria, let's start with you. Briefly, what is the current state of the Affordable Care Act and what's the latest from Washington in the debate around Obamacare?

Allison Hoffman: So you know, after seemingly overwhelming odds that Obamacare repeal and replace wouldn't happen this year, it's been a real year of, "Will they? Won't they?" on the GOP front and what will that actually look like. I think that's created a lot of uncertainty across the board in healthcare, from providers to insurers. And it didn't die with Graham-Cassidy. I think that there were sighs of relief from the left when that happened and when that died. But right now all eyes are on the current tax overhaul plan in Congress.

I think also on the Senate side, that plan would repeal the individual mandate, which is obviously a huge issue and a huge cornerstone of Obamacare. So Republican lawmakers have actually said that they think it would set the stage and make it easier for overhaul to pass next year. So at the same time there are real questions over Medicaid's expansion and the future of that issue. Officials, like Semma Verma, the head of CMS, kind of have been critical recently of the expansion population kind of using Medicaid as a vehicle for serving so many – or so-called working-age able-bodied adults. So kind of have hinted and indicated that they want to allow states to put more restrictions on Medicaid expansion.

Hagana Kim: Now Allison, backing up just a bit, in your analysis, has the ACA been successful?

Allison Hoffman: If you think about what the main goal of the ACA was, it was to expand the number of people in the country who have health insurance. So when this law was passed, about 17 percent of the population, 45 million people, didn't have any health insurance. And so the law does many things. The law has 10 titles. It touches on healthcare delivery. It touches on public health in a number of different areas. But the main goal of the law was to get insurance to those people who didn't have it, and it did it through two ways. It did it through an expansion of the Medicaid programs, which Victoria was just talking about, and it did it through changing the
way that private insurance works, so that more people could get access to private insurance. And both of those things have been relatively successful, and both have hit road blocks.

For example, the Medicaid expansion, the idea was that all low-income people in the country would have access to Medicaid. And it used to be that you had to be both poor and also be a child or be a pregnant woman or be a person with a disability. And the goal was that all states would expand their program to people who were poor, which is defined as earning up to 133 percent of the federal poverty level, which is still under $30,000.00 for a family of – of about $30,000.00 for a family of four, just under that. And so the law was challenged in many ways, both legal and legislative.

And one of the challenges, early challenges to the law, was that the Medicaid expansion was beyond Congress's authority. And the Supreme Court, in a surprise to many people who were following it, lawyers and academics and others, the Supreme Court agreed and said that requiring the states to expand up to this level or – the terms of the law were – or lose their existing Medicaid funding was coercive. And if you look at before the ACA, on average, about 10 percent of a state's budget was federal dollars for the Medicaid program. So the ACA said to the states, "Expand to more people or lose that existing money." And so for the first time, in looking at this kind of federal spending condition on a state program, the Supreme Court looked at this and said, "Congress, you've gone too far."

And the effect of that was that the states could then chose to expand or not expand. And so 30 states chose to expand and then remaining states my still expand, but 20 states still have not expanded. And what that meant was that initially the projections for how many people would be covered under Medicaid after the law were a lot higher than they have ended up being in reality, as it's played out in practice.

If you look at the bottom line, the goal of the law was that by 2020, 30 million more people in the U.S. would have health insurance. So you would have instead of 50 million uninsured, at that point you would have 20 million uninsured, and it's been about 10 million less than projected. So if you look today, the ACA has expanded access to health insurance to about 20 million people, which is a success, but is not all the way to universal coverage. But neither was the law intended to be that. So I would say overall it has been a success, but it has been one that has hit road blocks and has had setbacks along the way as well.
Hagana Kim: Now Victoria, what kind of healthcare will consumers find on healthcare.gov and the state exchanges? Is it equivalent to what employer-sponsored health plans look like?

Victoria Pelham: You know, I think it's similar, it covers the same essential health benefits that Obamacare mandated and tried to include as cornerstones of health insurance, to ensure that everyone had access to the same types of plans. Their networks tend to be narrower, based on doctors who are willing to give more discounts for these patients. They also tended to be cheaper on exchanges than those, often around 40 percent cheaper in some cases. So even though premiums have started to go up, and there's been a lot of talk about it becoming incredibly expensive, it's still an affordable healthcare option.

Hagana Kim: And so how are these state exchanges performing? What are some of the challenges that they're facing?

Victoria Pelham: Right now it's a period of open enrollment, so it's actually had a surprisingly strong start despite a lot of conversation going in that the Trump administration had sabotaged the open enrollment process, but they're still looking at likely fewer people signing up onto the exchanges. I think there were some estimates as low as 8 to 8.5 million people. Some analysts were saying one million less than last year's – or than the 2017 period, which was about 12.2 million. So it could be significantly fewer people in the plans. That could drop even more if the individual mandate is repealed under the Senate tax overhaul plan.

Several insurers are pulling out of the exchanges. That has been an issue. Financial performance wasn't exactly what they were hoping for when they signed up and there's some speculation that – Anthem for example – could drop out of the exchanges this year. But that remains to be seen. There's also kind of a lot of conversation about premium increases for enrollees, and 2018 costs are really still up in the air and still in question.

The Trump administration last month announced a plan to end the cost-sharing subsidies for insurers to allow them to cover – that was allowing them to cover low income patients on the exchanges. And there's been a lot of talk about how insurers might load those extra costs onto silver plans. So that could bring premiums up more. There's also kind of some conversation that GOP lawmakers are thinking mandate repeal could raise those premiums. Healthier
people could skip out on coverage as a result of not being required to be insured. So that could also affect the premium costs.

_Hagana Kim:_ Allison, we've heard a lot from the Trump administration about repeal and replace. Is that still a realistic outcome, and if there is a replacement, what would that look like?

_Allison Hoffman:_ It's getting harder at this point. I was optimistic from the beginning that repeal and replace would be hard. I thought that Congress would get more traction over the summer than they did. They had a good window over the summer where they had authorization to pass legislation with 51 votes in the Senate. So it was a period of time when it would have been easier to pass something. And I thought they would have gotten a little more traction than they did. But the fact that they weren't able to pass something over the summer suggests that repeal and replace is unlikely. It's definitely an uphill battle, and if we look at what happened over the summer, there's are a few reasons for it.

The first and most obvious one was that substantively there wasn't a good plan in place. There was no obvious kind of republican or conservative to the Affordable Care Activity, in large part because if you look at the evolution of ideas about health reform and health insurance over the past couple of decades, a lot of the ideas that were built into the Affordable Care Act were the republican ideas for health reform over those decades. So there was no obvious alternative for them to turn to. It's a market based reform. It builds on the involvement of private industry. It's many of these kinds of things that have been tenants of republican health reform in the past.

Another lesson that I was hoping was true and did play out is that with policies, you come to a tipping point where social policies start to become ingrained in the social fabric, and people get used to them and they rely on them. And when you have something like an increased access to health insurance, people who didn't have insurance before start getting access to health care. They get screenings. They learn that they have things that they didn't learn about before. They're able to be treated. They then survive. Their families know it. Their communities know it. People are able to get access to necessary medications in a way they haven't before and so once people get used to that, and then you start talking about taking it away from them, it's very hard to do. And so that's when we saw the unpopularity across the states, even with republican governors and legislators. And we saw kind of the resistance with people who knew their constituents were gonna be harmed. It
seems like the ACA has lived long enough that it has reached that tipping point.

So I don't think we're gonna see wholesale repeal and replace coming from Congress. That said, we are going to see continued erosion of some of the Affordable Care Act's policies. So Victoria was talking about some of these pieces. We've just seen recently that leading up to open enrollment, the administration, through executive order and through regulation, has been really challenging the exchanges to try to get them to fail this year. At least that's what it looks like from the outside.

So we've seen things like they're not funding navigators, who are the people who help enrollees find the right plan and buy insurance. They've shortened the open enrollment period, the number of weeks during which people can buy a policy. They've shut down the website for a period of hours on Sundays, which is when many people do enrollment. They're not paying out – as Victoria said, the cost sharing, the dollars to help poorer people buy actual care, cost-sharing deductibles and copayments. And a number of other policies that make it easier for healthy people to opt out of the exchanges, which makes it harder to have a stable pool of people in these exchanges buying policies. It makes it harder for insurers to predict and write policies. So they're doing a number of things that make it more challenging for insurers to want to play and we're gonna continue to see that in many different forms.

I mean, we see it through the tax bill. The potential repeal of the individual mandate is another version of this. There are pieces in the law that allow states to experiment with different forms of policy. One of them is called a 1332 waiver, and it says to a state, if you can kind of maintain levels of good coverage, you can try to do this in different ways. And the administration has discretion over – the states apply to have one of these waivers. They put a plan in place. And then the administration has discretion either to approve or deny it. And they've been encouraging the states to use these opportunities to experiment more. And so the question is, how far will they let them experiment. Will they let them experiment to the point that it's kind of outside the bounds of what the ACA intended in terms of access to affordable care on the ground. So that's another question. That one will be a big issue that will be played out over the next year. So I don't think we'll see full repeal and replace. I think we will see this to be a continued battleground from many different angles.
Hagana Kim: Now as a policy expert, where should be go from here? Should we be looking at other countries models? Is it realistic that they can be implemented here? What are your thoughts on a path forward?

Allison Hoffman: Well, there are lots of paths forward and there is lots of room for improvement. So if we pull the lens way back and we think about health policy in the U.S. in general and in broad strokes, we can learn a lot from around the globe. There are studies that are done on an annual basis by the commonwealth fund, that shows that we spend about twice as much per person on health care in this country, even adjusted for GDP, as other developed countries, and we have worse outcomes. We have lower life expectancy. We have higher infant mortality. We're spending a lot and we're not getting a lot for it. And there's a number of reasons for this result.

One of the reasons is the fact that we're the only country among the group that doesn't have universal coverage. And so what we get is we get disparities in outcomes based on the fact that some people have access to good healthcare and other people do not. We pay also pay a lot more for each unit of care than other countries. So we pay more for every doctor's visit, every day in a hospital, every surgery, every pill, every Band-Aid. That has been kind of picked up in the news with $100.00, $1000.00 Band-Aids. We pay more per every unit of care that we use, and we use a more expensive mix of services. We have a tendency toward higher-end technologies or goods and services that may not have great outcomes. So in the long-term, if we think about where we are comparatively, there's significant room for improvement.

There's no on other country's system that you could pick up and put in the U.S. and improve our system. We're a path dependent system. It's been evolving for years, and we're not gonna see that wholesale transformation, but we can take a lot from other countries and what they do well in order to try to either decrease what we're spending or improve our outcomes. Even without that kind of wholesale transformation, there's a lot that can be done in the short term incrementally.

So if you think about what health policy would have looked like if we had president Clinton now instead of president Trump, there would have been a lot going on in the short term to try to get the rest of the states to expand their Medicaid programs who hadn't expanded yet. There would have been attempts made to stabilize the exchanges, to try to get more insurers in, to try to keep the policies affordable in the exchanges. And the bill by Senators Alexander and Murry is an example of an effort to do so now that's
still in play, so we may see some of those short term incremental efforts happening. But that's an area for short term kind of incremental improvement.

Another thing that we see when we look at the Affordable Care Act is that we have some programs that work well, and we should continue to build on them. So if you look at the Medicaid expansion, it has been quite successful in terms of getting people access to health care and health insurance. The Medicare program works well. That could be another area where we could continue building out. And the CHIP program, the Children's Health Insurance Program, is a really successful program for getting health insurance to low income kids, and the deadline for reauthorization of that program just passed. And it's in Congress's hands now to determine whether to continue to fund that program going forward. So a very, very short term improvement would be Congress to reauthorize the CHIP program, which would be a short-term move that could have a tremendous positive impact for kids’ health. So lots of room for improvement both short term and long term. Unclear what we’ll see from this Congress and this administration in the short term.

_Hagana Kim_: Victoria, your thoughts about the future or lessons that you think we can learn from others?

_Victoria Pelham_: Yeah, I think that right now in Washington, all eyes are on the Congressional tax overhaul plan. There's a lot at stake if it were to go through. The individual mandate, if it were to be repealed, the CBO, Congressional Budget Office, estimates that 13 million people could lose health insurance. Those in favor, on the other side of the coin, are saying that by removing the penalty for not having insurance, low income people could essentially get, in essentially, a form of a tax cut.

I think also, right now, as Allison was saying, a lot of the issues are no longer – a lot of people in the Medicaid sphere in particular no longer see it as the possibility for a full repeal and replace necessarily, but a lot of action will happen at the state level through waivers and different kinds of administration policies that could be eroding certain parts of the Affordable Care Act.

A lot of Medicaid analysts see the program, the safety net program, as a real winner of the Obamacare debate this year. As more people became aware of what it actually does, who it covers, how many people, including seniors, are insured under the program, a lot of people learned its value, including the public, but also
lawmakers. And as such it kind of turned their efforts away from drastically restructuring it and its funding to different kinds of efforts to tweak some of the policies and programs.

At the same time, while the GOP continues to push repeal in some ways, and officials are still calling expansion into question, states are starting to push the issue themselves and could be the forefront of the battleground going forward. At the same time Semma Verma was making comments about the working-age, able-bodied adults, Maine actually voted to expand Medicaid, and it was the first to do so through a ballot initiative. So that was kind of unique, but it also could fuel the fire for different states who have already mulled that kind of expansion effort. It's not possible in every state, like Texas, but Utah and Idaho potentially could vote on a similar initiative next year, and could get that on their ballots. So that will be definitely something to watch for in 2018.

_Hagana Kim:_ Allison and Victoria, thank you so much for joining us. This has been a fascinating discussion, and thank you for joining us for this episode of _Case in Point._

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