

# Affordable Care Act: Lifting the Curtain on Health Care Costs



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We have reached a pivotal point in the evolution of the Affordable Care Act (ACA). Many of the most comprehensive reforms encompassed in the law will become effective in 2014, and these milestones will be the focus of the media and public debate for the next several months.

To date, many of the mandates in the ACA have not been felt by the public, as the first four years of the ACA have created the background for reform: such as establishing insurance exchanges, determining what constitutes minimally acceptable insurance benefits, as well as clarifying the individual mandate and employer responsibilities. However, on Jan. 1, 2014, promises made to the public in 2010 finally came to fruition.

At its core, the ACA is a law requiring insurance reform, and it is these components of the law that will fundamentally alter the way Americans are covered for health care and protected from medically related financial disaster. Pre-existing conditions are no longer a barrier to insurance coverage, limits on the total outlay of medical expenses allowed under an insurance policy (“lifetime caps”) have been eliminated, and individuals may now purchase insurance with the benefit of group pricing through the exchanges.

All insurance plans purchased through the exchanges and most other private plans must provide many preventive services at no cost to the patient, i.e. with no copayment or coinsurance, even if the patient has not met their full deductible. Patients may now receive benefits such as colorectal, depression or diabetes screening; diet and smoking cessation counseling; and a wide variety of immunizations at no cost. Similarly, women will now have access to breast-feeding assistance, breast and cervical cancer screening and other services specific to women’s health at no cost.<sup>1</sup>

As positive as these changes are to millions of Americans, particularly those who were not previously insured, the public is waking up to an underlying reality of the ACA. For most Americans, until now the cost of health has been a limited deductible and a copay at the doctor’s office window.

This is not to say people have not had to dole out some of their own money for health care, but for the well-insured the amount they have paid is nowhere near the actual cost of the care they have received. Those days are over; their out-of-pocket costs for health care will increase in the post-ACA era.

Total expenditures related to health care are limited under the law, but visits to their provider, ensuing tests and prescriptions can all add up to out-of-pocket outlays as high as \$6,350 annually for an individual and \$12,700 for a family<sup>2</sup> (with lower caps for individuals and families that receive credits toward their premiums). The sticker-shock across the country is similar to an employee who recently had his or her benefit package switched to a high-deductible plan, where seeing a doctor is not as carefree as it may have been before.

The specter of paying more for health care as it is consumed has resulted in outcry in the public and in the press. As a country, we are being jolted out of our fiscal blindness of years past; health care is far more expensive than we have been led to believe or for which we have been held responsible. Increased personal responsibility for the cost of health care is not an unintended consequence of the ACA; it is part of the law’s design.

## A veil over the cost of care

America’s clouded view of health care finances began innocently enough. During World War II, employers started offering insurance benefits to incentivize employment among a diminished pool of workers when a government-imposed wage freeze aimed at fighting inflation prohibited competition for higher wages.

What started as a recruitment tool, however, created a culture that equated work with guaranteed health care coverage at “no cost;” those costs were enveloped into a



benefit package. Family coverage for employees also became the norm, and those expenses were also folded into a “work benefit” with an invisible price tag. Over the ensuing decades, health care and health insurance became “free,” for it was a right of employment hidden behind the paycheck.

Two decades later, another significant blind was raised between the American public and the cost of care with the passage of Medicare and Medicaid on July 30, 1965, when President Lyndon B. Johnson signed the amendments to the Social Security Act.<sup>3</sup> Since that time—regardless of income—patients over the age of 65 have been able to consume health care with a personal outlay (such as paying for Medicare Part B or a supplemental policy) that has been exponentially cheaper than the actual cost of their care.

With the best of intentions, we created a system where the Medicare

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end-user has minimal (if any) financial considerations when scheduling an appointment or procedure, regardless of how often they seek care or for how long (for there is no lifetime cap on Medicare benefits).

Similarly, the poor have been able to access health care under Medicaid, particularly childbearing women, minor children and the disabled (subject to state-specific regulations). The State Children’s Health Insurance Programs (CHIP) in 1997 further extended the federal safety net to children whose parents’ annual earnings were just outside the limit for Medicaid.

Although in most states there are still large sections of the poor popu-

lation not able to access care (such as able-bodied, adult males), Medicaid and CHIP further detached a portion of the population from seeing health care’s ballooning costs.

Another significant change in the public’s comprehension of the cost of care occurred with federal legislation in 1986 that prohibited the “dumping” of the poor from emergency rooms in the country’s more affluent hospitals; since the Emergency Medical Treatment and Labor Act (EMTALA), the public has known that they cannot be refused at the ER door, regardless of ability to pay, without a medical screening exam, stabilization, and—in many cases—hospitalization or transfer for intervention.

All of these altruistic endeavors have resulted in a significantly healthier population than we had before the mid-20th century, and I can argue that all are examples of key American ideals that have been put into action. To be clear, I am not arguing against these federal initiatives or their impact, rather I seek to illustrate how all have contributed to our country's cultural ignorance of health care cost.

For the majority of Americans who have had affordable health insurance, accessing care has been facilitated by a divorce from payment. As a country, we have unintentionally and incidentally created a society of overindulged consumers who have high expectations with little financial responsibility.

## No register in the exam room

The disconnect between a patient's demand and the price of their health care has been further compounded by medical education. Generations of young physicians, raised in families where health care was "free," have been taught that it is unprofessional—even unethical—to let cost dictate care.

Our third-party payer system has fostered this illusion; when the entity paying the bill is not in the exam room, it becomes easier to order any and all care that may be applicable to a patient's condition, regardless of its expected effectiveness.

To further distort the role of professional judgment, television ads, fads and the Internet have fed the public's desire for increased intervention. The physician can prescribe, treat and dictate care in a world where their decision-making is separated from price, alone in an exam room with a patient both receptive and appreciative of the care that they receive but for which they do not pay.

We have created a model where the only party feeling the financial pinch of the doctor's orders is an

employer, private insurance company, or government agency hundreds of miles away from the locus of care.

## The curtain was ripping

This system has always been unsustainable in the long run, and—long before the ACA—it was falling apart, which is why we have had decades of reform attempts culminating with the ACA in 2010.<sup>4</sup>

Health care as a benefit of employment has strapped employers as the cost of insurance has escalated dramatically. By 2011, only 52.4 percent of employers were even offering insurance anymore, according to a study by the Robert Wood Johnson Foundation,<sup>5</sup> and many of those employers who continued the practice offered limited policies, excluded families and most commonly, switched to policies with high deductibles.

Medicare is famously sapping our government, where the costs for a patient easily outstrip the amount he or she paid into Medicare throughout their average of 45 working years. Ironically, we're living longer thanks to the care we can now access through Medicare, so the number of years a Medicare beneficiary is alive and consuming has grown significantly.

When President Johnson signed the law, a man's life expectancy was approximately 67 years and a woman's approximately 73.<sup>6</sup> Now, according to the Social Security Administration, a man 65 years old today can expect to live, on average, until age 84, and a woman of the same age until she is 86. But as the SSA cautions, "those are just averages ... about one out of every four 65-year-olds today will live past age 90, and one out of 10 will live past age 95."<sup>7</sup>

To intensify the problem, in a world where the patient and family are not responsible for the cost of care, it becomes easier to advocate for more and more as a loved one declines with age. Of the approxi-

mately \$554 billion in Medicare expenditures in 2011, 28 percent (about \$170 billion) was spent on patients' last six months of life.<sup>8</sup>

Although the difficulty of decision-making about end-of-life care can not be over-stated, we have alleviated the financial strain of medical care that is requested more out of an inability to let a patient die than any expectation that person will be restored. In that sense much of Medicare spending at the end of life may constitute misplaced grieving.

Those eligible for Medicaid have been taught, too, that they can access care with little to no thought about cost or location. Many routinely use the ER as the point of entry to the health care system (whether a matter of convenience, habit or preference), although that model is far more expensive and does not offer the continuity of care that working with a dedicated primary physician can provide.

A community's health care outcomes (particularly with chronic conditions such as diabetes) do not shift in the manner that would result with ongoing, preventive treatment, and the care prescribed by the ER is frequently not acted upon, as it may fall out of Medicaid coverage (e.g., new line antibiotics, lifestyle changes, and procedures that are expensive and elective). The "free" health care that we have established through programs for the poor has resulted, ironically, in accessing the most expensive care with little to no long-term impact on that community's health.

EMTALA has been particularly damaging to hospital providers, as the public has been trained to go to the ER even for nonemergency care. This is particularly prevalent among the poor, who are not eligible for assistance, such as an able-bodied man who has an acute illness or injury that could be adequately treated in an office setting, but who goes to the ER because it is "free."



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## Unpaid medical bills are the number-one cause of bankruptcies in this country.

Since the passage of EMTALA, hospitals have treated patients of this nature with no reimbursement at all, a situation that will continue in states that have decided not to expand Medicaid under the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*.<sup>9</sup>

### The dark side of the 'good old days'

Although many Americans are bemoaning the loss of the health care that was for the most part unlimited and inexpensive (the remembrance undoubtedly clouded by the current backlash against the ACA), current public despair does not reflect reality under the old, traditional insurance policies. The truth is, beyond financial instability, there is another, even darker, reason why the system we created over the past half-century was a failure in public policy.<sup>10</sup>

Americans have been deluded for more than five decades into thinking that the insurance coverage that they purchased or gained through employment offered them protection from financial ruin resulting from a medical disaster. This has always been an illusion at best and a lie in hundreds of thousands of cases. Until now, insurance companies have been able to drop people from their plans with few restrictions.<sup>10</sup>

Even if a policy was continued before the insurance reform mandated by the ACA, private insurance policies (as opposed to Medicare) have contained lifetime caps on what the policy would cover. Having paid premiums year after year (whether directly or through their employment benefit

package), an untold number of people have fallen off that insurance cliff.

Families confronted with a disabled child, patients with significant head or neurologic injuries, and cancer survivors requiring years of costly intervention are all examples of people who have personally seen their insurance shield vanish on the breath of a diagnosis or in a split-second accident.

Unpaid medical bills are the number-one cause of bankruptcies in this country,<sup>11</sup> a shameful reality ignored by many and unknown by most. Only a Medicare beneficiary has a guarantee of "to the grave" care. The outcry about the loss of "cheap care" is naïve.

No one has been protected by our insurance system before the ACA; in the midst of the hue and cry about out-of-pocket costs, the media and masses are missing that they are now, truly safe from financial ruin after a medical disaster.

### The pain of out-of-pocket costs

Health care insurance as envisioned by reformers generally and the ACA specifically will bring a new level of financial awareness to patients in this country, at least until they reach Medicare eligibility. Faced with the implications of the high deductible included in most levels of policies available in the exchanges, Americans will become cost-conscious consumers.

The CEO who injured his knee on his morning run will consider the cost of a cortisone injection versus the time commitment of the recommended physical therapy; the mother seeking an

antibiotic for a child who has no fever or other signs of bacterial infection will have to weigh her skepticism over the doctor's diagnosis, and the cost of the pill (if she can still get it); and the diabetic who finds it unpleasant to control his eating impulses will face the unpleasant cost of more frequent (and avoidable) trips to his doctor.

Alternatively, people who do not want the high deductible (and who have the means to avoid them) will pay more for their policy up front. On the other side of the spectrum, Medicaid patients will feel a new reality as well.

Once the EMTALA requirements are met, Medicaid patients are more likely to be steered to free options in community clinics for nonemergency care or face a charge for the same care, if they insist upon being treated on the spot in the ER. The world of "free" medicine is changing. We all will be investing in our own health care.

At the same time, under the ACA, people are now truly protected. The policies that are finally available to everyone will protect against the unthinkable and cataclysmic. With no lifetime caps and specific limits to our out-of-pocket expenses, we can all now rest assured that our insurance will be there when we most need it.

No longer will people facing disability, impending death or decades of expensive treatment have their devastation compounded by bankruptcy. Even homelessness is expected to decrease in the country as medical-related bankruptcies are eradicated by the ACA.<sup>12</sup>

It's important to note that the ACA's goal is to no longer provide care to a population without financial skin in the game; this result is not an unintended consequence. Consuming without a price tag is over.

With the dawn of 2014, the American public is waking up to a completely altered reality about who ultimately pays for care, and it is understandable why so many are now

experiencing sticker shock when fully understanding the implications of the "new world" under the ACA. Health care is no longer free, yet—then again—it never was.



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