The Affordable Care Act: Effects of the Healthcare Reform

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Clare Cho
Department of Agricultural, Environmental, and Development Economics

Mark D. Partridge, Swank Professor of Rural-Urban Policy
Department of Agricultural, Environmental, and Development Economics

Swank Program Website: http://aede.osu.edu/programs/swank/
## Table of Contents

1  Executive Summary  
3  Introduction  
5  Overview of the Affordable Care Act  
9  Benefits and Concerns  
15 Implications for Ohio  
19 Conclusion  
20 References

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) reforms the healthcare system in the United States with the aim of expanding coverage, curbing healthcare costs, and preventing insurance companies from varying premiums according to health status. A successful implementation requires most individuals to have health insurance, either provided by the government, an employer, or individually purchased. To ease the transition into the new healthcare system, the government is offering subsidies and expanding Medicaid.

The Affordable Care Act has numerous provisions; many have been implemented but a few important ones remain:

- **December 23, 2013**: Individuals who want or need coverage by January 1, 2014 must be enrolled in the insurance exchange marketplace.
- **January 1, 2014**: The individual mandate is implemented, requiring individuals without employer-provided insurance to purchase coverage. Eligible residents of states that have expanded Medicaid will begin to receive coverage. Also, small businesses will be eligible for health insurance tax credits for two consecutive taxable years.
- **March 31, 2014**: Those who have not purchased health insurance will have to pay a penalty.
- **January 1, 2015**: The employer mandate is implemented: employers with over 50 employees must provide health insurance or pay a penalty.

Since its inception, the Affordable Care Act has been a controversial legislation, spurring discussions about potential advantages and disadvantages. When healthcare reform is fully implemented, evaluations of its effect will be crucial. As discussed in depth in this policy brief, the main issues are:

- **Individual mandate**: The main attraction of the individual mandate is that an estimated 26 million additional Americans will receive healthcare coverage (CBO 2012). However, it is unclear how effective the legislation will be since the Supreme Court has ruled that states can opt-out of the Medicaid expansion. More than one-third of uninsured individuals reside in California, Florida, and Texas; currently, Florida and Texas are unlikely to expand their Medicaid programs (Haberkorn 2013; Advisory Board Company 2013).

- **Employer mandate**: The employer mandate raises concern that, as the economy continues to recover from the recession, businesses will avoid hiring new employees or reduce employees’ hours to avoid the cost of providing health insurance. To incentivize small business owners to provide health insurance, the ACA provides tax credits for eligible businesses and creates a separate insurance market for employers with fewer than 50 employees (the Small Business Health Options Program). However, these tax credits might not motivate small businesses to provide health insurance when the time limit of two consecutive taxable years begins on January 1, 2014.

- **Insurance marketplace exchange**: The ACA requires all insurance companies to provide standardized summaries of benefits and coverage to improve comparability of insurance plans. Ideally, this new system helps individuals make informed decisions on which insurance plan to purchase. Since the website’s October 1st launch, technical difficulties have raised concern that individuals will not be able to enroll in time for the implementation of the individual mandate in 2014. In addition, it is unclear whether the new system will increase competition because some insurance companies are ending coverage in certain states.

- **Hospitals and clinics**: The ACA increases transparency of healthcare costs by standardizing the amount of coverage insurance companies must provide for each type of plan, making it possible to determine the exact cost of services. Although this helps individuals make informed decisions regarding healthcare, many have been complaining that the new mandate forces insurance companies to drop their preferred insurance plan. The ACA also increases administrative costs for hospitals and clinics.
For smaller hospitals and clinics that tend to have a small administrative staff, this additional cost could reduce patients’ options for medical providers, particularly in rural communities.

- **For Ohio:** In addition to the benefits and concerns mentioned in the bullets above, there are several concerns specific to Ohio. Governor John Kasich expanded Medicaid eligibility through the Ohio Controlling Board rather than passing a bill through the state legislature (Cheney 2013). The expansion will likely result in a lawsuit, which may limit the effectiveness of the individual mandate. Although the employer mandate has been delayed for a year, it is unclear how it will affect businesses recovering from the recession. None of the urban counties in Ohio, aside from Central Ohio, are close to recovering; Cuyahoga County is not forecasted to fully recover until 2023 (Smith 2013). It is also unclear whether the ACA will increase competition among insurance companies in Ohio. Aetna, the nation’s third largest insurance company, stated that it will not be joining the insurance exchange in Ohio. In addition, some insurance companies only work with one hospital in certain counties, which could affect an individual’s decision to purchase healthcare from that company (Sutherly October 2013).

It is unclear what the effects of the ACA will be, and whether the potential benefits or concerns mentioned above will be realized for the individual and employer mandates and the insurance exchange market. The full effect of such a transformative legislation may not be known for years, but continuous monitoring of the changes that occur will be necessary to ensure the effectiveness of the new healthcare system.
**Introduction**

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. The legislation is a comprehensive reform of the healthcare system in the United States, intended to “reduce health care costs and make coverage more affordable for all Americans” (The White House). The legislation follows Massachusetts’ 2006 healthcare reform by using a “three-legged stool” approach:

1 – reforming the insurance market to ensure coverage for individuals with pre-existing conditions and preventing insurance companies from varying premiums according to health status;
2 – requiring individuals to purchase health insurance (the individual mandate) and for employers to provide it (the employer mandate), and
3 – offering subsidies and expanding Medicaid to assist individuals and employers during this transition.

The second provision is necessary to implement the first, and the third assists the transition into the new healthcare system; the first component cannot be

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**Figure 1: States' Positions for Supreme Court Case**

Adapted from: Musumeci (July 2012)
* Total includes District of Columbia
Note: Iowa and Washington were on both sides of the case because each state’s governor and attorney general took opposite sides (hence both states are counted twice in the totals, making the total 53 instead of 51)

1 The April 2006 Massachusetts reform was titled: “An Act Providing Access to Affordable, Quality, Accountable Health Care”. See www.mahealthconnector.org.

2 Excluding slight adjustments for age and smoking status.
The second and third provisions have encountered opposition since the day the legislation was signed into law.

The day that President Obama signed the ACA into law, the state of Florida filed a lawsuit challenging the constitutionality of the legislation, specifically for the individual mandate and the Medicaid expansion. An additional 25 states joined Florida\(^3\), two of which supported certain aspects of the legislation, as shown above in Figure 1. The National Federation of Independent Business and individual plaintiffs who did not have health insurance filed their own lawsuit, which the Supreme Court heard concurrently with Florida’s lawsuit.

On June 28, 2012, the Supreme Court released its decision that the individual mandate was constitutional, but that requiring states to expand Medicaid was not. The judges claimed that the structure and implementation of the individual mandate acted as a tax, although it was not labeled as one in the legislation (Musumeci 2012). They ruled that states had to be given the choice to opt-out of the Medicaid expansion\(^4\) because states had insufficient time to consent to the legislation. The judges also stated that the penalty of withholding federal Medicaid funds for not expanding eligibility was too severe, since these funds can make up over 10% of a state’s budget. Certain provisions of the ACA had been implemented prior to the Supreme Court decision, such as extending dependent coverage for children up to the age of 26, but the verdict ensured that the individual mandate would go into effect.

According to a poll conducted by the Pew Research Center and the USA Today (2013), only 25% of those surveyed said they understood the law well, while 34% said they had little or no understanding of how the law would impact them. Another poll conducted by the Kaiser Family Foundation (2013c) found that 51% of the public continues to say that they do not have enough information to understand how the legislation will affect them. This policy brief addresses this confusion by providing an overview of the Affordable Care Act and discussing the potential benefits and concerns that have been raised, nationally and specifically for Ohio.

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\(^3\) Virginia also filed a lawsuit but the Supreme Court refused to hear its case.

\(^4\) See Musumeci 2012 for more information on the Supreme Court decision
Overview of the Affordable Care Act

Several provisions of the ACA have already been enacted, such as dependent coverage for children up to the age of 26, a 10% tax on indoor tanning services, and the creation of a non-profit Patient-Centered Outcomes Research Institute intended to compare the effectiveness of medical treatments. However, its main purpose is to reform the healthcare system using a “three-legged stool” approach: the individual mandate, the employer mandate, and the insurance marketplace exchange. Therefore, this brief will focus on these three categories. This section will explain the changes made by the legislation for each category. Section 3 discusses the benefits and concerns that have been raised, including how hospitals and clinics will be affected. Finally, section 4 will focus on how Ohio will be affected.

A. Individual Mandate
Beginning January 1, 2014, every individual must purchase health insurance. This requirement is necessary to avoid adverse selection, where mostly individuals with poor health purchase insurance. Under the ACA, health insurance companies will no longer be allowed to vary premium rates for individuals according to health status, including those with preexisting conditions. This means insurance companies will be unable to minimize their risk by providing different rates. If the majority of individuals with insurance are unhealthy, the cost for insurance companies would rise and premium rates would escalate substantially. For the ban on dropping individuals with pre-existing conditions to be sustainable, a sufficient number of healthy individuals need to purchase insurance to keep costs down.

Figure 2: Medicaid Expansion by State

Adapted from: Advisory Board Company (2013)
* Total includes District of Columbia
5 For information on all of the provisions and the enactment date, see http://kff.org/interactive/implementation-timeline/.
To ensure a sufficient number of healthy individuals purchase health insurance, individuals who do not purchase it by March 31, 2014 will be required to pay a fee. Exemptions are provided for those with an income below the threshold for filing for a tax return or if purchasing health insurance would cost more than 8% of their income, after employer contributions and tax credits. The fee will be phased in gradually, the greater between a flat fee and percentage of taxable income: $95, $325, and $695 or 1%, 2%, and 2.5% in 2014, 2015, and 2016, respectively (Kaiser Family Foundation).

According to the projections made by the Congressional Budget Office (CBO), the ACA will increase the number of individuals with health insurance by about 26 million people (CBO 2012). Recognizing the burden it places on low-income individuals by requiring all citizens to purchase health insurance, the ACA includes a provision to extend Medicaid coverage to all individuals below 133% of the federal poverty level. Prior to the legislation, the federal government only matched Medicaid funds for individuals with dependent children, forcing states to run their own program or receive a Section 1115 waiver. Effective April 2010, states were given the option to expand eligibility early. By March 2012, five states and the District of Columbia had chosen to do so (Kaiser Family Foundation 2012).

The Supreme Court’s ruling on the constitutionality of the ACA allows states to opt-out of extending Medicaid eligibility to adults without dependent children. As of November 6, 2013, according to the Advisory Board Company (2013), 25 states and the District of Columbia are expanding Medicaid eligibility and an additional four states are considering it, illustrated in Figure 2. The remaining 21 states are not planning on expanding eligibility. States’ positions continue to be updated, with members of certain states’ government opposing the expansion. In Ohio, there may be an impending lawsuit from the state legislature and other groups to prevent the Medicaid expansion, discussed further in Section 4.

B. Employer Mandate

The employer mandate is a provision in the ACA requiring employers with over 50 personnel to provide health insurance. Its implementation was delayed by the Obama administration until January 2015 because of concern that the mandate might slow the recovery from the recession, discussed further in section 3b. Employers are affected differently based on the number of employees they have—whether they have 25 or fewer, 25 to 50, or more than 50. A report by Sommers (2003) found that, in 2002, 97.8% of firms with 50 or more employees offered health insurance, but only 63.5% of firms with fewer than 50 employees did. Therefore, since firms with 50 or fewer employees may be unable to afford it, only firms with 50 or more employees are penalized for not providing their employees health insurance.

Beginning January 1, 2015, employers with over 50 employees must pay a fee if they do not provide health insurance for all of their employees. The only exception is if none of the employees receive a premium tax credit or cost sharing subsidy in the insurance exchange market (Kaiser Family Foundation 2013a). The fee is $2,000 x (number of full-time employees – 30), which is also the maximum penalty an employer will receive. If the employers provide insurance but do not pay at least 60% of health care expenses, the employees can participate in the insurance exchange and receive a premium tax credit. Employees can also choose to participate in the insurance exchange and receive a premium tax credit if they pay more than 9.5% of their family income for coverage under the plan offered by their employer. In either of these cases, the employer must pay ($3,000 x the number of employees who are participating in the insurance exchange), up to the aforementioned maximum penalty. Self-employed individuals without any other employees will not be considered an employer and may use the individual insurance exchange marketplace to find coverage.

To incentivize smaller firms to offer their employees health insurance, businesses with fewer than 25 full time employees may be eligible for small business Health Care Tax Credits. Beginning in 2010, employers with fewer than 25 full time employees who pay an average annual wage below $50,000 but contribute 50% or more towards their employees’ health insurance premiums have been eligible for up to a 35% tax credit. The tax credit will increase to a maximum of 50% beginning in 2014. These tax credits

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6 Individuals are also exempt from the fee for the following reasons: member of a religion opposed to health insurance policies, incarcerated, or member of an Indian tribe.

7 This is the flat fee for adults; the flat fee for children is half the fee for adults. There is a family maximum of $285, $975, and $2,085 for 2014, 2015, and 2016, respectively.

8 For more information on Medicaid eligibility, see http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html.

9 Section 1115 waiver redirects a portion of the federal funding to the state to the Medicaid program, rather than providing additional funds. See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html for more information.

10 There are exceptions for employees who have abnormally high healthcare expenses.
credits were available without a time limit starting in 2010, but beginning in 2014, employers will only be able to claim the tax credit for two consecutive taxable years\textsuperscript{11}.

To improve employer-based health coverage, all businesses that offer their employees healthcare must provide a Summary of Benefits and Coverage form\textsuperscript{12}, explaining the healthcare plan offered by the insurance company. In addition, the waiting period for a new employee to receive health coverage must be less than 90 days. Beginning in 2015, businesses will also be required to report the health coverage they offer their employees to the federal government. By compiling this information, it will be possible to evaluate whether employers are providing their employees with sufficient healthcare coverage.

C. Insurance Exchange Market

The insurance exchange marketplace opened on October 1, 2013, allowing individuals to determine their eligibility for different insurance plans and compare them\textsuperscript{13}. States have chosen to offer a federally facilitated exchange, partnership exchange, or a state-based exchange. In other words, states offer an insurance marketplace that is operated entirely by the federal government, partially by the federal government, or entirely by the state. As of May 28, 2013, 17 states had declared a state-based exchange, 7 were planning on having a partnership exchange, and 27 defaulted to the Federal exchange, as shown in Figure 3.

The ACA requires all health insurance providers to use a standard form for their summary of benefits and coverage, making insurance plans more easily comparable (DHHS 2012). The standard form will make the cost of each service covered by the insur-

Figure 3: Insurance Exchange Marketplace by State

Adapted from: Kaiser Family Foundation (2013d)
* Total includes District of Columbia

\textsuperscript{11} See U.S. Small Business Administration for more details: \url{http://www.sba.gov/healthcare}.
\textsuperscript{12} Every insurance company will be required to create one for each plan they offer. See \url{http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC.pdf} for a sample of the form.
\textsuperscript{13} The insurance marketplace can be accessed at \url{https://www.healthcare.gov/marketplace/individual/}. 
ance plan more transparent, helping the market perform more efficiently. It also creates a glossary\(^4\) of commonly used health coverage and medical terms, such as “co-insurance” or “deductible”, to ensure that every individual understands the coverage provided by each insurance plan. Unfortunately, the website used for the marketplace has been experiencing difficulties since its inception, discussed further in Section 3.

Every insurance plan must provide a minimum package of 10 “essential” services, similar to the federal benchmark plan listed in Table 1. If a state does not choose or create a benchmark plan, the plan with the highest enrollment will be used. As of May 2013, about half of the states had selected a plan and the remaining states defaulted to the plan with the highest enrollment (Cassidy 2013). In addition to providing “essential services”, insurance companies must spend at least 80% of the premium dollars on medical care rather than on administrative costs. If an insurance company fails to do so, it must provide a rebate to the individual or employer. Each insurance company must offer four levels of coverage in the exchange market: bronze, silver, gold, and platinum, which cover 60%, 70%, 80% and 90% of the benefit costs, respectively (Kaiser Family Foundation 2013b). All of these plans must provide the aforementioned essential health benefits and have an out-of-pocket limit set at the Health Savings Account (HSA) current law limit, which was $5,950 for individuals and $11,900 for families in 2010 (Kaiser Family Foundation 2013e). These out-of-pocket limits are reduced to one-third of the HSA limit for those with incomes between 100% and 200% of the federal poverty line, one-half for 200% to 300%, and two-thirds for 300% to 400%. Insurance companies must also offer a catastrophic plan in the individual exchange market. This plan provides minimal coverage set at the HSA level and is only available to those who are under 30 years old or exempt from coverage\(^5\).

<table>
<thead>
<tr>
<th>Table 1: Minimum Set of Essential Services</th>
</tr>
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<tbody>
<tr>
<td>Ambulatory patient services</td>
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<tr>
<td>Emergency Services</td>
</tr>
<tr>
<td>Hospitalization</td>
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<tr>
<td>Maternity and newborn care</td>
</tr>
<tr>
<td>Mental health and substance use disorder services</td>
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<tr>
<td>Prescription drugs</td>
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<tr>
<td>Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>Laboratory services</td>
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<tr>
<td>Preventative and wellness services and chronic disease management</td>
</tr>
<tr>
<td>Pediatric services, including oral and vision care</td>
</tr>
</tbody>
</table>

Adapted from: Cassidy 2013
Source: Affordable Care Act of 2010, Sec. 1302 (b)


\(^5\) See Kaiser Family Foundation 2013e for more details.
Benefits and Concerns

The ACA has been controversial, with members of Congress attempting to prevent it from being enacted on multiple occasions. On October 2013, some members of Congress attached a clause to defund the ACA to a government spending bill (Cohen, Botelho, and Yan 2013). This led to a political impasse, resulting in a government shutdown for 16 days, during which “non-essential” government operations were closed. Both opponents and advocates of the legislation had valid arguments to justify their positions. Although the main components are necessary for the legislation to be effective and could be beneficial, they also raise concerns.

A. Individual Mandate

The individual mandate is necessary to prevent adverse selection, which occurs when mostly individuals with poor health purchase insurance, driving costs up. Opponents argue that the individual mandate requires excessive government involvement in individuals’ lives and claim that it infringes on personal liberty (i.e. Conover 2012 and Moffit 2011). Although the Supreme Court deemed the provision constitutional, opposition continues to persist, as exemplified by the House of Representatives’ attempt to delay its implementation for another year in bill H.R. 2668 (Young 2013). Advocates of the legislation argued that such a delay would leave millions of Americans uninsured and cause a substantial increase in premiums, caused by the Medicaid expansion and insurance companies’ inability to vary premiums according to an individual’s health (Blumberg and Holahan 2013 and Park 2013). Nonetheless, it remains unclear how premiums will change if a large number of healthy individuals forego insurance and choose to pay the penalty instead.

The White House (2013) estimated that healthcare coverage would be extended to an additional 34 million Americans, one of the main benefits of the individual mandate. The Supreme Court ruling allows states to opt-out of the Medicaid expansion. In states that opt-out, childless residents with an income below 133% of the federal poverty line and families between 100% to 133% will not receive coverage through Medicaid. According to the CBO’s re-estimation, approximately two-thirds of individuals

Figure 4: Diagram of Who Benefits from Individual Mandate

<table>
<thead>
<tr>
<th>Health</th>
<th>Benefit from Individual Mandate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Benefit from Individual Mandate</td>
<td></td>
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</tbody>
</table>

Adapted from: Krugman (2013)
who would have been eligible for Medicaid have an income too low to qualify for exchange subsidies (CBO 2012). The updated CBO projection estimates 26 million uninsured individuals will benefit from the ACA, which reduces total projected costs by about $84 billion for the period 2012 to 2022.

Although the line was positioned arbitrarily, Figure 4 illustrates that those with high levels of income or good health may not benefit from the individual mandate. Those with good health generally do not need costly healthcare coverage. Those with high income have been relatively unaffected by higher premium rates, but now pay a higher Medicare tax. On January 1, 2013, the ACA increased the Medicare tax by 0.9% for unmarried individuals with an income higher than $200,000 and for married couples filing jointly with an income higher than $250,000 (IRS 2013). Those with lower incomes and poorer health are positioned to benefit much more from the individual mandate. The Medicaid expansion will now cover those individuals below 133% of the federal poverty line and the government is providing health insurance subsidies for individuals below 400% of the federal poverty line (Kaiser Family Foundation 2013e). Those with poor health can now purchase more affordable insurance because insurance companies are no longer allowed to vary premiums based on health status.

The effect of the individual mandate will be influenced greatly by how it is implemented in California, Florida, and Texas, the three states with the most uninsured residents. Texas stated that it will not expand Medicaid and Florida will most likely do the same (Advisory Board Company 2013). According to Haberkorn (2013), more than one-third of the 46 million uninsured individuals in the U.S. reside in these three states, partially because the total number of residents is higher than the national average.

According to the Annual Social and Economic Supplement to the Current Population Survey, about 18% and 22% of residents in California and Florida, respectively, were uninsured in 2012. Texas had one of the highest percentages of uninsured individuals since 1999, at almost 25% in 2012. Across the nation, the percentage of individuals who are uninsured or on Medicaid or Medicare has been increasing since 1999, as illustrated in figure 5. The

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16 The tax also increased for married taxpayers filing taxes separately with an income above $125,000.
17 Part of the increase in the percentage of individuals on Medicaid may have been influenced by states that chose to participate in the early expansion of Medicaid.
percentage of individuals directly purchasing their own insurance or uninsured has remained fairly consistent around 25%. These individuals may benefit from the increased transparency in the new insurance exchange market and from potentially being eligible for subsidies.

States that expand Medicaid will receive federal funding to cover the total cost for the first three years. Thereafter, the federal government will slowly phase down their contribution to 90% of the total cost by 2020. States that expanded Medicaid eligibility early will receive a phased in increase in federal medical assistance so they receive the same contribution by 2019 (Kaiser Family Foundation 2013e). A study conducted by Price and Eibner (2013) found that states that chose to opt-out of expanding Medicaid would have a net increase in short-term spending by providing uncompensated care to those individuals who would have been eligible for Medicaid. Although the prospect of receiving federal funds incentivizes states to expand Medicaid, as illustrated earlier in Figure 2, a number of states chose to opt-out because of the cost it would impose after the first three years as well as general opposition to the ACA.

Because the ACA was modeled after Massachusetts’ 2006 reform, examining how healthcare changed in Massachusetts after the reform can provide insight on the possible effects of the ACA, although the results may not be the same on a national scale. Courtemanche and Zapata (2013) found that individuals in Massachusetts reported an improved self-assessed health after the implementation of healthcare reform. The greatest improvements were among low-income and non-white individuals, near-elderly adults, and women. These results are promising, but not a guarantee of similar results across the nation after the ACA is fully implemented. Healthcare reform in Massachusetts did not face as much controversy as the ACA; the general opposition to the ACA may result in lower effectiveness.

B. Employer Mandate

Because the U.S. economy is still recovering from the recession, the employer mandate raised concern that small businesses would avoid hiring new employees or reduce employees’ hours to avoid the cost of providing health insurance, particularly those close to the 50 employee benchmark (i.e. McVeigh 2013). Although there have been employers stating that they will reduce employees’ hours because of the ACA, Water (2013) found that the recession was the main reason for the recent increase in part-time workers, and that there has not been a significant increase since the ACA was signed into law. Nevertheless, because of the uncertainty regarding employers’ response, the White House delayed the implementation of the employer mandate until January 1, 2015 (Mazur 2013).

Based on a nationally representative telephone survey, the National Federation of Independent Business (2011) found that only 42% of employers with 50 or fewer employees offered health insurance one year after the ACA was signed into law, a 2% decline from the previous year. According to the survey, 12% of small employers have had their insurance plan terminated or been told that their current insurance plan will not be available in the future. When asked whether they would offer health insurance next year, only 34% of surveyed small business owners responded “very likely” while 37% responded “not at all likely”.

From 1996 to 2002, although the percentage of individuals working at firms offering health insurance increased, the percentage of individuals eligible for the healthcare plan and the number of enrolled individuals decreased (Stanton 2004). This trend is only partially explained by the increased number of individuals enrolling on their spouse’s insurance plan. Cooper and Schone (1997) found that the decline in employer based coverage was from declining take-up rates, despite increases in offer rates and accessibility. They found that the decline in take-up rates was caused by various factors, including increasing costs of insurance and premiums. Another study conducted by Cutler (2003) confirmed this finding: the increase in cost to employees was the principal reason for decreased enrollment. According to data collected by the Center for Financing, Access, and Cost Trends, the average employee premium contribution has been steadily increasing, rising 65.2% for individual employee coverage from 1996 to 2002 and about 55.8% for employee family coverage (Stanton 2004).

In addition to providing tax credits, the ACA creates a separate insurance exchange for small business employers, titled the Small Business Health Options Program (SHOP). Small businesses currently pay 18% more for health insurance, on average, than big businesses because of higher administrative costs (U.S. Small Business Administration). SHOP allows small businesses to pool their risk together to obtain higher quality insurance policies for a lower cost. This should improve small business em-

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18 The White House released this information on July 2, 2013 through the Treasury blog.
19 The report states this net change could be the result of sampling error. The survey has ±3.7 margin of error.
20 Database can be found at http://meps.ahrq.gov/mepsweb/.
21 Average contribution increased from $342 to $565 for individuals and from $1,275 to $1,987 for family coverage.
players’ ability to provide insurance for their employees without incurring a significant cost. Using data obtained from five states and Washington DC, Skopel and Kronick (2013) found that the lowest cost silver plan available to small employers in 2014 will be 18% less expensive than they would if the current trend in average premiums continues. Beginning in 2014, the program will be available for employers with up to 50 employees; by 2016, it will expand to employers with up to 100 employees.

Although the tax credit may have benefited small employers already providing health insurance, the benefit may not be sustained because of the two year time limit that will be implemented in 2014. The National Federation of Independent Business (2013) raised concern that the availability of the tax credit is too short to effectively reduce costs for small employers. They cite rising healthcare costs as the main challenge for small employers who provide health insurance. Since these businesses may operate on thin profit margins, any additional cost could have a significant impact. Although the tax credit may provide temporary relief, in the third year, small businesses would face a significant cost increase if the cost of healthcare continue to rise.

C. Insurance Exchange Market

The insurance marketplace is intended to create a more organized and competitive market for health insurance plans (Kaiser Family Foundation 2013e). The requirement that insurance companies create easily understood summaries of benefits and coverage allows individuals to compare insurance plans more easily. The uniform standard of coverage will guarantee that each individual receives coverage for “essential” services. Each insurance company must offer four levels of coverage to help individuals decide how much more they are willing to pay for higher coverage. These improvements in the comparability of insurance plans will help individuals and employers determine which plan fits their needs.

Despite these benefits, the new requirements for insurance companies have also generated troubling stories of insurance companies ending coverage in certain states. UnitedHealth Group Inc and WellPoint Inc have reported that they will be limiting their involvement in individual insurance exchanges (Humer 2013). Aetna pulled out of at least five exchanges after submitting proposals in 14 states because they believe their rates will not be competitive (Lubby 2013). A report released by McKinsey and Co. found that about one-third of insurance companies have chosen to stop offering coverage in certain states, resulting in fewer companies in approximately half of the states (O’Donnell and McGinnis 2013). This raises concern that the predicted increased competition across insurance companies will not occur, particularly in rural areas.

Fewer insurance companies tend to locate in rural areas because they are hesitant to enter a new market, particularly when hospitals are scattered across the region and there are few potential customers. According to Abelson, Thomas, and McGinty (2013), about 58% of the 2,500 counties using the federally facilitated exchange only have one or two insurance companies participating. The Obama administration states that 95% of Americans live in areas with at least two insurance companies, but experts claim this may be insufficient competition (Abelson et al. 2013). Rural Baker County, GA, only has one insurer; an individual on the silver plan in Baker County would pay twice as much as the same individual in Atlanta, where there are four insurers. According to Stephen Goldsone, chief executive of WINHealth, only one county in Wyoming is served by more than one hospital and in southwest Georgia, Blue Cross and Blue Shield is the only insurer in 54 of the 159 counties (Abelson et al. 2013).

Other insurance companies, such as WellPoint, are embracing the exchanges and stated that they plan on being “essential players” (Lubby 2013). Alan Weil, executive director of the National Academy for State Health Policy, stated that the absence of larger insurers may be beneficial for individuals because smaller regional companies tend to be more competitive with premiums. Sabrina Corlette, a senior research fellow at Georgetown University Health Policy Institute, stated that as large insurance companies move out of the marketplace in certain states, smaller companies that only serve the Medicaid market may begin to replace them, a trend already seen in Rhode Island and Oregon (O’Donnell and McGinnis 2013). However, Weil raises concern that these smaller insurers may not have the extensive network of hospitals and doctors that larger insurers have (Lubby 2013).

The concern that there would be an insufficient number of physicians was raised before Massachusetts implemented its healthcare reform as well. Instead, there has been a rise in access to care, as the number of working-age adults having regular doctor visits, preventative care, and dental care have increased (Long and Masi 2009). Nevertheless, survey respondents reported difficulty finding physicians that would accept their insurance, particularly low-income individuals. The insurance exchange marketplace is located on

22The five states are Colorado, New Mexico, Oregon, Vermont, and Washington.
a website that should allow individuals to easily compare insurance plans. The effectiveness of the insurance marketplace relies on the website functioning properly. Since the website launched on October 1, 2013, it has faced technical difficulties. Although the Obama administration initially blamed unexpected high traffic on the website, it has become apparent that the website must be revamped (Millman and Epstein 2013; Weaver, Ovide, and Radnofsky 2013). Information technology experts have stated that the software coding techniques used on the website are inefficient and unable to handle the demand, which may require a complete system overhaul (Weaver, Ovide, and Radnofsky 2013; Kennedy 2013). There are critical security concerns that have been raised as well, but Marilyn Travisner, the administrator of the Centers for Medicare and Medicaid Services, stated that many of the problems have been addressed and that the website will work smoothly for the majority of individuals by the end of November (Pear 2013). In addition, the Obama administration announced that experts are addressing the problems with the website (Millman and Epstein 2013). Nevertheless, these technical difficulties raise concern of whether it will be possible to implement the individual mandate on time, especially for individuals wanting or needing coverage by January 1, 2014.

D. Implications for Hospitals and Clinics

One of the main motivations for the ACA was increased transparency by providing more information on costs to help individuals make informed decisions about their healthcare (DHHS). As a part of this effort, the Department of Health and Human Services released data from more than 3,000 hospitals on how much common inpatient services cost (CMS 2013). Combined with the standards set for different levels of insurance coverage and the creation of research centers to examine cost variation across hospitals, the ACA informs consumers about healthcare costs that have remained relatively hidden in the past.

Although the transparency of healthcare costs can benefit individuals by allowing them to make informed decisions, there is concern about how this may disrupt negotiations that used to occur between insurance companies and hospitals (NPR May 2013). Since new regulations have a standard percentage of healthcare costs that must be covered by each type of plan, large insurance companies will be unable to bargain down costs on the basis of having a large number of covered patients. While this may allow smaller insurance companies to become more competitive, it could result in higher premiums for those enrolled under large insurance companies’ plans. It is unknown whether negotiations between insurance companies and hospitals were common, and therefore unclear whether there will be an increase in premiums after the implementation of the new policies.

The different regulations and monitoring created by the ACA introduces a higher administrative workload. While large hospitals that tend to have a large administrative staff should be unaffected, it may be detrimental for smaller hospitals and clinics (NPR...

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April 2013). If the costs are high enough, smaller clinics may be forced to join larger hospitals, particularly with the steady increase in large hospitals since 1998, illustrated in Figure 6. Large hospitals dominated the market in 2011, with the highest percentage of hospitals employing over 1,000 individuals (31%) and an additional 18% employing 500 to 1,000 employees (see Figure 7).

The effect of the legislation on smaller hospitals and clinics may be more pronounced in rural areas, where nearly half the hospitals have 25 or fewer beds and suffer from physician shortages (American Hospital Association 2011). Approximately 10% of rural counties do not have a primary care physician and urban counties have almost 2½ times as many specialists. Rural hospitals already have difficulty managing the fixed costs of operating a hospital because of the low-patient volumes. The added administrative costs may strain the limited staff and capital resources in rural hospitals, which have been struggling with the dramatic shift from inpatient to outpatient care caused by technological advancements (American Hospital Association 2011).

Furthermore, by expanding Medicaid and requiring individuals to purchase healthcare, it is unknown how free clinics will be affected (Watts 2013). The combination of higher administrative costs and the reduction of patients may diminish the number of smaller clinics and heighten the power of hospitals. It will be important to observe whether insurance companies work with hospitals and vice versa, particularly in rural areas that tend to have smaller clinics.

![Figure 7: Percentage of Hospitals Across the US by Employment Size (2011)](source: County Business Patterns: General Medical and Surgical Hospitals (NAICS 622110))
Implications for Ohio

The benefits and concerns discussed in the previous section are applicable to every state. The likelihood and extent to which they occur in each state, however, will vary. This section provides a more in depth examination of the effect the ACA has had in Ohio and the potential effects it may have once all the provisions are implemented.

A. Individual Mandate

Since 1999, similar to the national trend, the percentage of individuals who are uninsured, purchasing their own insurance, on Medicaid, or on Medicare has increased in Ohio. Conversely, the percentage of individuals receiving employer-based insurance has decreased substantially, as illustrated in Figure 8. The percentage of individuals on Medicaid or Medicare increased by about 10%, while the percentage of uninsured individuals also increased, but has remained below the national average for all 12 years. In addition to extending coverage to uninsured individuals, anecdotes of how individuals with pre-existing conditions or health problems will benefit from the ACA have begun to surface (i.e. Sutherly September 2013).

On October 21, 2013, Ohio expanded its Medicaid program. Governor John Kasich endorsed the expansion in February. He bypassed the legislature because of its inaction and implemented the expansion through the Ohio Controlling Board24 (Palmer 2013). Governor Kasich argued that the Board could adjust state funding to accept an increase in federal

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24 The Ohio Controlling Board is a special legislative panel composed of six legislators and one of Kasich’s appointees. The Board adjusts the state budget to reflect fluctuations in federal funding.
funds through increased Medicaid enrollment. With a 5-2 vote, the board increased federal funds in the state budget (Cheney 2013). Nevertheless, there are signs of an impending lawsuit; 39 legislators in the state government have protested Governor Kasich’s actions.

The Ohio Medical Expansion Study (2013) was conducted by the Health Policy Institute of Ohio, The Ohio State University, the Urban Institute, and the Regional Economic Modeling, Inc. to inform the state legislature about the potential effects of expanding Medicaid. By bringing together these institutions, different methods could be used to predict the effects of expanding Medicaid. The study found that, although the increase in Medicaid enrollment would increase costs, the expansion of Medicaid would yield substantially greater savings.

The savings reported by the Ohio Medical Expansion Study (2013) come from shifting the following costs from the state to the federal government: spend-down adults, the Breast and Cervical Cancer Program (BCCP), inpatient prison, and retroactive and other pre-Managed Care Organization. The revenue is estimated using taxes on managed care plans, the increase in federal Medicaid funds, and rebates from prescription drugs sold at pharmacies.

As seen in Table 2, these additional savings and revenue are greater than the cost from increased Medicaid enrollment; thus, Ohio has a net gain from expanding Medicaid. The study notes, however, that the forecast must be interpreted with caution; it is uncertain if the current costs and revenues will remain consistent.

### B. Employer Mandate

As Ohio continues to recover from the recession, the employer mandate could further delay the progress counties have made thus far. Although Central Ohio is recovering quickly, a study conducted by Chmura Economics and Analytics found that none of the other urban counties in Ohio are close to recovering from the recession, with Cuyahoga County forecast to fully recover in 2023 (Smith 2013). The PNC bank conducted a survey of Ohio business owners and found that 63% of them stated that the ACA has not affected their staffing plans (Williams 2013). Although this indicates that employment for the majority of businesses should be unaffected by the ACA, there is a large percentage of businesses that may reduce the number of employees they have. The expected number of added jobs and sales remained consistent with the previous spring and fall 2012 surveys, indicating that business owners remain cautiously optimistic.

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Increased state costs from more Medicaid enrollment</th>
<th>Savings</th>
<th>Revenue</th>
<th>Net state fiscal gains</th>
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<tr>
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<td>UI</td>
<td>OSU</td>
<td>UI</td>
<td>OSU</td>
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<td>2014</td>
<td>13</td>
<td>22</td>
<td>53</td>
<td>59</td>
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<td>2015</td>
<td>30</td>
<td>48</td>
<td>110</td>
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<td>2016</td>
<td>38</td>
<td>57</td>
<td>185</td>
<td>240</td>
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<td>2017</td>
<td>147</td>
<td>156</td>
<td>191</td>
<td>307</td>
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<td>2018</td>
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<td>196</td>
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<td>2019</td>
<td>347</td>
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<td>2020</td>
<td>472</td>
<td>439</td>
<td>208</td>
<td>406</td>
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<tr>
<td>2021</td>
<td>580</td>
<td>529</td>
<td>215</td>
<td>431</td>
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<tr>
<td>2022</td>
<td>617</td>
<td>559</td>
<td>226</td>
<td>458</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,529</strong></td>
<td><strong>2,421</strong></td>
<td><strong>1,587</strong></td>
<td><strong>2,792</strong></td>
</tr>
</tbody>
</table>

Adapted from Ohio Medicaid Expansion Study 2013

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25The Urban Institute used a microsimulation model, similar to the one used by the CBO, The Ohio State University applied an actuarial approach, and the Regional Economic Modeling, Inc. used a Tax-PI model. See article for details (Ohio Medical Expansion Study 2013).

26Currently, individuals who accrue sufficient medical expenses receive coverage because they are characterized as “medically needy”. To ensure an individual qualifies, each monthly requirement must be checked, an often costly administrative process. By enrolling individuals based on income instead, these administrative costs will be eliminated.
rently, it is difficult to fully assess what the effect on Ohio businesses will be, particularly because the employer mandate has been delayed until 2015. It may be the end of the decade before the full effect is realized.

**C. Insurance Exchange Market**

Ohio is one of the states where certain insurance companies are ending coverage. Although Aetna, the nation’s third largest insurance company, had submitted multiple proposals and pricing to the Ohio Department of Insurance, it will no longer be offering insurance through the exchange (Luhby 2013). Susan Millerick, a spokesman from Aetna, explained that the company determined that there was no need to have two separate plans in the exchange, and that Coventry Health Care, an insurance company recently purchased by Aetna, had a more competitive plan in Ohio (Provance 2013).

There is concern that Ohio consumers will have limited options for physicians and hospitals according to their health insurance plan, particularly if large insurance companies, such as Aetna, no longer offer coverage. CareSource offers the lowest-cost public marketplace plan in Ohio and is only accepted at The Ohio State University’s Wexner Medical Center in Franklin County (Sutherly October 2013). Anthem Blue Cross and Blue Shield only has Mount Carmel Health System hospitals as a provider in Franklin County. If consumers’ insurance plans limit the number of providers they can choose from, the insurance exchange marketplace may not induce the desired competition. Kathleen Gmeiner, project director of Ohio Consumers for Health Coverage, remains optimistic despite Aetna’s withdrawal, noting that 13 other companies will offer coverage through the exchange (Provance 2013). Furthermore, Aetna’s withdrawal may provide smaller insurance companies an opportunity to enter the market and improve competition. Yet, to determine the full effect of the insurance exchange, changes must be monitored and assessed in the upcoming years.

**D. Implications for Hospitals and Clinics**

Similar to the national trend, the number of large hospitals in Ohio has increased since 1998, while smaller hospitals and clinics with less than 100 employees have had a downward trend (see Figure 10). As illustrated in Figure 9, large hospitals dominate the market in Ohio, even more than they do nationally. The greatest share of hospitals at 40% has 1000 or more employees, while hospitals with less than 100 employees only make up 4% of the market. The additional administrative cost created by the ACA may force smaller hospitals and clinics to close, which could be detrimental for potential patients, particularly in rural areas. According to the 2008 Ohio Family Health Survey, adults in rural communities are less likely to consider themselves to be in poor health when compared to adults in metropolitan areas, but 30% more likely to have a heart attack (Frazier 2009). It will be imperative to monitor how the composition of hospitals and clinics change over the upcoming years, especially in rural areas.
Figure 9: Percentage of Hospitals in Ohio by Employment Size (2011)

Source: County Business Patterns: General Medical and Surgical Hospitals (NAICS 622110)

Figure 10: Change in Number of Hospitals in Ohio by Employment Size

Source: County Business Patterns: General Medical and Surgical Hospitals (NAICS 622110)
Conclusion

The main purpose of the Affordable Care Act is to reform the healthcare system to prevent insurance companies from varying premiums according to an individual’s health status. It has been a controversial legislation that has raised several potential benefits and concerns; the main ones are as follows:

- Extending healthcare coverage to an estimated 26 million uninsured individuals
- Whether employers will provide healthcare coverage, particularly small business owners, and whether employees’ hours will be reduced.
- Whether technical problems with the insurance exchange website will affect enrollment and competition among insurance companies, especially if they continue to withdraw from the exchange
- How smaller clinics and hospitals will be affected by higher administrative costs, particularly those in rural communities.
- How the legislation will affect the urban counties in Ohio struggling to recover from the recession

It is uncertain which of the benefits and concerns mentioned in this brief will occur once the legislation is fully implemented. Evaluations of the changes that occur will be crucial to improve the effectiveness of the Affordable Care Act, although the full effect may not be realized for years to come.


