Monitoring the Early Effects of the Affordable Care Act: Discussion

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Abstract
In the Spring of 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was enacted with major provisions to expand health insurance coverage, control health care costs, and improve the health care delivery system. While the major coverage expansions envisioned by the legislation are not scheduled to be implemented until 2014, several provisions of the law have already been adopted and planning efforts have been initiated for the core components of the act. In order to effectively plan, operationalize, implement and manage the vast array of programs set in motion by this act, there is critical need for content specific data that is both timely and accessible. Essential data resources will be required to facilitate effective program planning, administration and management, in addition to facilitating evaluations of program performance. While new data development efforts are essential to insure the effective administration of the various components of the Affordable Care Act (ACA), several existing data platforms helped inform the underlying framework of the legislation and will continue to be invaluable to its implementation.

The NCHS data systems covered in this session provide several examples of modifications to monitor the early effects of the ACA. The Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality, is another one of the core data resources utilized to inform several provisions of the Affordable Care Act. In this paper, attention is given to the current capacity of the MEPS, the NHIS and other DHHS healthcare surveys to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

The views expressed are those of the author and no official endorsement by the Agency for Healthcare Research and Quality or the Department of Health and Human Services is intended or should be inferred.

Key Words: Affordable Care Act, **NCHS data, MEPS**

1. Introduction

In the Spring of 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was enacted with major provisions to expand health insurance coverage, control health care costs, and to improve the health care delivery system. While the major coverage expansions envisioned by the legislation are not scheduled to be implemented until 2014, several provisions of the law have already been adopted and planning efforts have been initiated for the core components of the act. In order to effectively plan, operationalize, implement and manage the vast array of programs set in motion by this act, there is critical need for content specific data that is both timely and accessible. Essential data resources will be required to facilitate effective program planning, administration and management, in addition to facilitating evaluations of program performance. While new data development efforts are essential to insure the effective administration of the various

components of the Patient Protection and Affordable Care Act (PPACA), several existing data platforms helped inform the underlying framework of the legislation and will continue to be invaluable to its implementation.

The NCHS data systems covered in this session provide several examples of modifications to monitor the early effects of the ACA. The Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality, is another one of the core data resources utilized to inform several provisions of the Affordable Care Act. In this paper, attention is given to the current capacity of the MEPS, the NHIS and other DHHS healthcare surveys to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

2. Overview of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act is a comprehensive initiative that includes health insurance coverage expansions, health care cost control mechanisms, programmatic efforts to advance health care quality and efficiency, preventive care enhancements and targeted actions to improve the healthcare delivery system at large. While several of the health insurance coverage reforms have already been implemented in 2010, many of the coverage related provisions of the law will not take effect until 2014.

2.1 Health Insurance Coverage Initiatives

Among the health insurance coverage initiatives implemented in 2010, young adults up to age 26 are now eligible for dependent coverage under family plans; pre-existing condition exclusions for children's coverage have been eliminated; and all new group and individual health plans now provide first dollar coverage for preventive services. In addition, the law provides eligible uninsured individuals access to coverage with no exclusions permitted for pre-existing health conditions. The initial phase of a small business tax credit for qualified small businesses that contribute to employee coverage purchases has also been triggered. Furthermore, Medicare Part D enrollees that enter the "donut hole" now receive rebates. In 2014, Health Insurance Exchanges will be established in each state to enable individuals and small employers to comparison shop for standardized health benefits.

Premium tax credits for coverage will be made available through the Exchange for individuals with incomes above Medicaid eligibility levels and below 400% of poverty who are not eligible for or offered acceptable coverage. For states that opt in, Medicaid eligibility for nonelderly individuals will increase to 133% of poverty. Annual limits on the amount of coverage individuals may receive will be eliminated and health insurance regulations will be enacted that prohibit insurance carriers from refusing to sell or renew policies due to health status. In addition, most individuals will be required to obtain acceptable coverage or pay a penalty, and most employers with 50 or more employees who do not offer coverage will incur cash penalties as well.

2.2 Healthcare Cost Control Initiatives

In 2010, the Affordable Care Act created a grant program to support States in holding insurance carriers accountable for unreasonable rate increases. In 2011, health insurers were required to report on the share of premium dollars spent on medical care and provide consumer rebates where less than 80 to 85 percent of the premiums are used for

benefits. By 2013, the income threshold is increased to 10% of adjusted gross income for claiming itemized deductions for medical expenses, health flexible saving account contributions will be limited to $2,500, and the hospital insurance tax for high wage workers will be increased by 0.9% on earnings over $200,000 for individual taxpayers and $250,000 for married coupled filing jointly. In 2015, an Independent Advisory Board is to be established to submit proposals to Congress and the private sector to help lower health costs. For Medicare beneficiaries, a physician value-based payment program will be established to promote quality of care over volume of services. By 2018, an excise tax on the most expensive health plans is to be adopted.

2.3 Healthcare Delivery System Initiatives

In 2010, the Affordable Care Act provided additional resources to the Department of Health and Human Services to develop a national quality strategy and support quality measure development for the Medicare, Medicaid and CHIP programs. In addition, a private, non-profit Patient Centered Outcomes Research Institute was established to support comparative effectiveness research. An interagency council was also established to promote federal health policies and a prevention and public health investment fund created to advance these efforts. In 2012, physician payment reforms are to be adopted that enhance payment for primary care services and promote the formation of accountable care organizations to improve health care quality and efficiency. Quality outcomes for acute care hospitals are promoted by setting up a hospital value-based purchasing program. By 2013, health plans must adhere to uniform standards for the electronic exchange of health information to streamline administrative tasks and limit associated costs. In 2015, a planned Independent Advisory Board will also develop proposals for improving quality, efficiency and health outcomes in health care delivery, and expanding access to evidence-based care.

3. Enhancements to NCHS/CDC Data Systems to Monitor Components of the ACA

The NCHS data systems covered in this session provide several examples of modifications to monitor the early effects of the ACA. For example, the National Health Interview Survey (NHIS), is currently being used to monitor the early effects of the ACA. The NHIS already includes several questions to yield information to inform the ACA. These included several questions about health insurance coverage and healthcare access and utilization. In addition, a series of new questions explicitly designed to track ACA effects were added to the NHIS starting in 2010. In concert with these modifications, the NHIS sample size was increased starting in 2011 to enhance the ability to track ACA effects at the state level. NCHS staffs are involved in the analysis of the early effects of the ACA on insurance coverage trends and in the dissemination of resultant research findings. In addition, the release of NHIS public use data will enable researchers to conduct more detailed analyses to help measure the impact of changes in coverage associated with the ACA.

Questions that have been on the NHIS for several years are also being used to establish baseline estimates of access and health care utilization. Additional questions added to the NHIS in 2011 will provide more detail about topics in health care access and utilization addressed by the legislation. These additions are primarily focused on helping examine the following four topics: expanded access to health insurance and health care for young adults aged 19-25; effects of changes to public prescription drug benefits on misuse or

nonuse of prescription medication; public perception of the financial burden of medical bills; and trends in emergency room use along with the reasons for these visits.

There have also been a number of visible upcoming changes to the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) that will be useful for monitoring the effects of ACA. Changes in NAMCS include increased sample sizes allowing state-level estimates of preventive care given in physician offices and community health centers for 34 states. Changes in the NHAMCS will for assessments of ACA on crowding the emergency department in 5 of the most populous states. In addition, the National Hospital Care Survey (NHCS) has been re-engineered, with enhancements that improve the capacity to link data from NHCS to Medicare and Medicaid and death records in support of more comprehensive analyses.

There has also been increased interest in examining the capacity of the existing healthcare workforce, especially the primary care workforce, to provide care to individuals expected to be newly insured due to implementation of provisions of the Affordable Care Act. Data from the National Ambulatory Medical Care Survey, 2011 Electronic Medical Records Supplement have served as a particularly informative source to monitor healthcare workforce capacity as measured by the fraction of physicians accepting new patients. The data facilitate the derivation of estimates of the percent of office-based physicians who accepted any new patients and new patients with particular sources of payment both nationally, and for states.

4. Measurement of Trends in Health Care Cost, Coverage, Access and Use: MEPS Data Infrastructure

Health care expenditures currently exceeds one-sixth of the United States gross domestic product, exhibit a rate of growth that exceeds other sectors of the economy, and constitute one of the largest components of the Federal and states' budgets. Although the rate of growth in health care costs has slowed in the past few years, costs continue to rise, in particular for hospital care and prescription medications. As a result, the question of how to design a system that encourages the provision of high quality care as efficiently as possible remains an issue of continuing concern to both private and public payers. In a similar vein, an evaluation of the current health care system requires an understanding of the patterns and trends in the use of health care services and their associated costs and sources of payment. To effectively address these issues, researchers and policymakers need accurate nationally representative data to better permit an understanding of how individual characteristics, behavioral factors, financial incentives, and institutional arrangements affect health care utilization and expenditures in a rapidly changing health care market.

The growing demand for accurate and reliable information on the populations health care utilization, expenditures, insurance coverage, sources of payment and access to care served as the catalyst to initiate the implementation of the family of national medical expenditure surveys sponsored by the Agency for Healthcare Research and Quality (AHRQ) and its predecessor agencies. AHRQ's Medical Expenditure Panel Survey (MEPS) collects detailed information regarding the use and payment for health

care services from a nationally representative sample of Americans. The survey is cosponsored by the National Center for Health Statistics, CDC. Westat and RTI are the primary data collection organizations.

The MEPS research program, broadly defined to encompass data collection, data development, research and the translation of research into practice, is directly tied to the strategic goal of identifying strategies to improve access, foster appropriate use and reduce unnecessary expenditures. Few other surveys provide the foundation for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, and racial/ethnic groups. The public sector relies upon the MEPS research findings to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. In the private sector, these data are also used to develop economic projections.

The Medical Expenditure Panel Survey (MEPS), initiated in 1996, is designed as a continuous on-going survey to permit annual estimates of health care utilization, expenditures, insurance coverage and sources of payment for the U.S. civilian noninstitutionalized population. Over the past several years, the MEPS data and associated research findings have quickly become a linchpin for the nation's economic models and their projections of health care expenditures and utilization. This combination of breadth and depth of the data enables public and private sector analysts to develop economic models designed to produce national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy. Since 1977, AHRQ's expenditure surveys have been an important and unique resource for public and private sector decision makers. The survey is unique in the level of detail of information obtained on the health care services used by Americans at the household level and their associated expenditures (for families and individuals); the cost, scope, and breadth of private health insurance coverage held by and available to the U.S. population; and the specific services purchased through out-of-pocket and/or third-party payments.

The MEPS data support a wealth of basic descriptive and behavioral analyses of the U.S. health care system. These include studies of the population’s access to, use of, and expenditures and sources of payment for health care; the availability and costs of private health insurance in the employment-related and non-group markets; the population enrolled in public health insurance coverage and those without health care coverage; and the role of health status in health care use, expenditures, and household decision making, and in health insurance and employment choices (Cohen et al., 2009; Cohen, 2003).

The MEPS consists of a family of three interrelated surveys: the Household Component (HC), the Medical Provider Component (MPC), and the Insurance Component (IC). The MEPS Household Component was designed to provide annual national estimates of the health care use, medical expenditures, sources of payment and insurance coverage for the U.S. civilian non-institutionalized population. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, demographic characteristics, employment and access to health care. Estimates can be provided for individuals, families and population subgroups of interest. Additional details about the MEPS component surveys can be found at www.meps.ahrq.gov .

MEPS derived estimates of the health insurance status of the U.S. civilian noninstitutionalized population are critical to policymakers and others concerned with access to medical care and the cost and quality of that care. Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. When estimating the size of the uninsured population, it is critical to consider the distinction between those uninsured for short periods of time and those who are long term uninsured across several years in duration. Compared to people with healthcare coverage, uninsured people are less likely to visit a doctor, have a usual source of medical care, receive preventive services, or have a recommended test or prescription filled. Consequently, individuals that experience extended periods of being uninsured are particularly at risk for restrictions in access to care and exposure to serious illness and significant financial jeopardy. Since many individuals undergo transitions in the acquisition and loss of health insurance coverage over time, an important consideration is the length of duration of spells of un-insurance and the capacity of this lack of coverage to lead to less efficient use of health care services and facilities. In this regard, MEPS research efforts have demonstrated that individuals who experience short spells of being uninsured differ significantly from those who have been uninsured for more than a year on several dimensions which include access to employer sponsored coverage, their attitudes and preferences regarding the need for coverage and their sensitivity to the cost of acquiring coverage. In addition to providing cross-sectional estimates of health insurance coverage each year, the MEPS has the added analytical capacity to identify individuals with gaps in coverage over time as well as the duration of the spells of being uninsured for up to four years.

In addition to measuring actual out-of-pocket financial burdens for health care, MEPS provides nationally representative data that can be used to measure the extent of underinsurance in the U.S. Underinsurance is defined as being at risk of spending more than a certain amount of family income on out of pocket expenses in the event of a catastrophic medical illness. Estimates of the underinsured require linked information on families health insurance benefits, family income, and risk of experiencing catastrophic medical events that are found in the MEPS.

With health care absorbing increasing amounts of the nation’s resources, the question of how to implement health system design innovations that encourage the provision of high quality and efficient healthcare delivery is a sentinel concern of both private and public payers. To effectively address this issue, researchers and policymakers have benefited from MEPS research findings to better understand how individual characteristics, behavioral factors, financial incentives, and institutional arrangements affect health care expenditures in a rapidly changing health care market. Research findings for the MEPS have also served to provide health care decision makers with a better understanding of the highly concentrated nature of health care expenditures and the persistence of these high expenditures over time. MEPS studies that examine the persistence of high levels of expenditures over time have been essential to help discern the factors most likely to drive health care spending and the characteristics of the individuals who incur them.

Since its inception, MEPS has been used in several hundred scientific publications, and many more unpublished reports. It has served as a core data resource for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, or racial/ethnic groups. Government and

non-governmental entities rely upon these data to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. In the private sector (e.g., RAND, Heritage Foundation, Lewin-VHI, and the Urban Institute), these data are used by many private businesses, foundations and academic institutions to develop economic projections. These data represent a major resource for the health services research community at large. Since 2000, data on premium costs from the MEPS Insurance Component have been used by the Bureau of Economic Analysis to produce estimates of the GDP for the nation. The data are also used to inform the national health care cost estimates in the National Health Expenditure Accounts and to assess time trends in the provision of employer health benefits by States.

5. MEPS and Implementation of the Affordable Care Act

In this section, attention is given to the current capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

5.1 Use of MEPS to determine the amount of the small employer health insurance tax credit.

Section 1421 of the Patient Protection and Affordable Care Act, specifies the rules for determining the amount of the small employer health insurance credit
In collaboration with the Office of the Secretary, DHHS and the Department of Treasury, AHRQ staff provided MEPS national and State level estimates of average premiums that were utilized to determine the small business tax credits for 2010 and subsequent years. More specifically, data from the MEPS Insurance Component were used to provide estimates of health insurance premiums by state for employer sponsored coverage provided by small employers of size 50 or less. The small employer health insurance tax credit was then determined based on the MEPS derived estimates of the average premium for the small group market in each State for the respective taxable year. These respective average premiums for insurance in the small group market in each State were also posted on the following IRS website http://www.irs.gov/pub/irs-drop/rr-10-13.pdf

The Secretary of Health and Human Services (HHS) also determines whether separate average premiums will apply for areas within a State ("sub-State areas") and also determines the average premium for a State or sub-State area. Data from the MEPS Insurance Component are currently being used help facilitate the derivation of comparable estimates of average premiums at the sub-State rating area level.

5.2 Use of MEPS to Evaluate the Health Insurance Status of Young Adults, Ages 22-25.

Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. Young adults are less likely to be covered by health insurance than their older counterparts. Effective September 2010, one component of the Patient Protection and Affordable Care Act permits adult dependents to remain on their parents' insurance plans until their 26th birthday. This coverage provision also applies to adult dependents under age 26 who no longer live with their parents, are not dependents on their parents' tax returns, or are no longer students. Using information from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) analyses have been conducted to obtain detailed estimates for the U.S. civilian noninstitutionalized population between the ages of 22-25, a group that

would typically be ineligible for continuance of coverage under their parents' insurance plans prior to 2010 (Cohen and Rhoades, 2010). http://www.meps.ahrq.gov/mepsweb/data_files/publications/st305/stat305.shtml . The MEPS will continue to be utilized to discern the changes in health insurance coverage take up by this vulnerable population that are attributable to enactment of the Affordable Care Act. In addition, the MEPS will be utilized to assess changes in health care access, related health care utilization, out of pocket and total expenditures incurred by such young adults as a consequence of this legislation and its impact on health status.

5.3 Use of MEPS to Evaluate the Health Insurance Status of High Risk Individuals. The Affordable Care Act now provides eligible uninsured individuals access to coverage with no exclusions for pre-existing health conditions. In the past, many high-risk individuals with multiple chronic conditions were virtually uninsurable. Using information from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) analyses are underway to determine the scale and characteristics of individuals under the age of 65 with multiple chronic conditions who were without health insurance coverage prior to enactment of the PPACA.

The MEPS will continue to be utilized to discern changes in health insurance coverage take up by this vulnerable population that are attributable to enactment of the Affordable Care Act. In addition, the MEPS will be utilized to assess changes in health care access, health care utilization, out of pocket expenses and total expenditures incurred by high-risk, chronically ill individuals as a consequence of this legislation and their subsequent impact on the health status of this vulnerable population.

6. Summary

With the enactment of the Affordable Care Act, the implementation of health reform and the assessment of its outcomes will continue to place growing demands on the Department of Health and Human Services data resources. Assessing the implementation of health reform initiatives, and evaluating the impact of health care reform efforts on general and priority populations and health care sectors will require accurate, reliable and timely data on all aspects of the health care system, from insurance coverage to health care delivery and costs, to health outcomes. In light of these growing demands and challenges, the Departments' Data Council has placed special emphasis on coordinated Department wide data planning that is responsive to the needs of these health reform efforts. Particular attention has focused on the effective use of our existing data infrastructure as a platform to meet current demands, and potential enhancements that can fill remaining gaps to produce the data required to support health reform efforts. HHS surveys provide most of the measures for the Health System Measurement Project and most health reform monitoring and evaluation efforts. As noted, questions have already been added to several of our HHS surveys to support ACA related monitoring efforts.

Currently, existing Departmental resources are being utilized to inform assessments of the health reform initiatives begun in 2010 and 2011. These reform initiatives include 1) the take-up and cost of coverage for young adults up to age 26 that stay on their parents health plans; 2) elimination of cost sharing for preventative services; 3) prohibitions against lifetime benefit caps; 4) the setting of small business tax credits; 5) initiating annual reviews of planned premium increases; and 5) administering rebates for Medicare Part D Enrollees in the "Doughnut Hole." Over the next several years, an increased demand is anticipated on existing and new data resources (both survey and administrative

data) and analytical capacity to support program management and evaluation as 2014 approaches, with the initiation of 1) planned Medicaid expansions, 2) new insurance market regulations including risk pooling and risk adjustment; and 3) the establishment of State Health Insurance Exchanges.

In the past year, visible returns on the current HHS investment in the Department's core statistical systems were evident in their capacity and relevance to Secretarial priorities. For example**,** health care reform initiatives specified in the recent reform legislation have relied heavily on the availability of accurate and comprehensive data on the characteristics of the uninsured, such as the take-up and cost of coverage for young adults up to age 26 that stay on their parent's health plans and the use of preventative services. These Departmental estimates of the number of uninsured, further distinguished by length of time without coverage, utilization and expenditure patterns, income levels and access to coverage are key parameters that have served to define core provisions of health reform proposals and their impact. In addition, available national and state level data in HHS on the cost of employer sponsored insurance coverage are also being utilized to estimate the cost and impact of planned reform initiatives. This critical information also serves to improve GDP estimates of the cost of health insurance and provide purchasers with comparative cost information, and these capacities are also well aligned with Departmental initiatives to improve value in health care.

Similarly, the existing capacity of our national HHS surveys on the characteristics of the long term uninsured population, the concentration of health care expenditures and expenses relative to income, and population estimates of health status, health care access, use and quality of care has served to identify disparities in health care and inform the HHS National Quality and Disparities Reports. In addition, ASPE's policy research, actuarial and economic analysis and microsimulation modeling capacities have been used to support White House and Departmental initiatives on health care reform. CDC surveys provide the scientific basis for understanding obesity and overweight, and for designing interventions to address the Secretary's priorities for healthy weight and tobacco control. The HHS portfolio of health care provider surveys and administrative data yield information on health care use, quality, costs and regional variation, as well as pandemic and emergency preparedness and health information technology adoption. Additional enhancements to the NCHS survey discussed in this session and the MEPS in these areas may serve to further optimize their alignment with Departmental needs to effectively plan, operationalize, implement, manage and evaluate several of the Patient Protection and Affordable Care Act programs.

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