How the ACA lowers patients' out-of-pocket costs

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Andis Robeznieks
Senior News Writer

Even as the fate of the Affordable Care Act is yet again tied up in the federal courts, the research in the medical literature demonstrating the positive impact of the Obama-era health care legislation continues to pile up.

For example, the Affordable Care Act has helped to soften the blow of traumatic injury by lowering out-of-pocket expenses for low-income patients and lowering the odds that such injuries would lead to a catastrophic health expenditure (CHE).

“Our findings provide evidence that the ACA was associated with significant decreases in the risk of financial catastrophe caused by trauma,” wrote researchers from Stanford University, the University of California at Los Angeles, and other institutions in a study that was published in *JAMA Network Open*.

In a study conducted prior to the onset of the COVID-19 pandemic, researchers examined a national sample of 6,288 working-age adults who had emergency department or hospital visits for traumatic injury from 2010 through 2017. Implementation of the ACA was associated with 31% lower odds of CHE—defined as out-of-pocket spending plus premiums exceeding 19.5% of family income—for the entire group, and 39% lower odds for those in the lowest income group.

“In contrast to other types of illness, trauma is less likely to be influenced by improved access to primary and preventive care and remains a substantial source of financial risk to patients despite ongoing efforts to improve access,” the researchers wrote. Their work adds to previous research showing that 70% of uninsured patients who experience traumatic injury in the U.S. are at risk of incurring catastrophic out-of-pocket expenditures.

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The researchers divided the patients into four income groups:

- Lowest, earning 138% of the federal poverty level (FPL) or below, and eligible for Medicaid
in most states.
Low, earning 139% to 250% of the FPL, eligible for cost-sharing and insurance premium subsidies on the ACA-enabled individual insurance marketplaces.
Middle, earning 251% to 400% of the FPL, eligible for premium subsidies.
High, earning more than 400% of the FPL, and ineligible for subsidies.

During the eight years studied:

The uninsured rate dropped from 22.2% to 15.1% for the entire cohort, and from 34.6% to 23.5% for the lowest-income group.
Medicaid enrollment increased from 16.6% to 24.7% for the full cohort, and from 42.7% to 55.4% for the lowest-income group.
Coverage purchased from the ACA’s insurance marketplaces went from 0% to 3.6%.

While no significant drop in out-of-pocket spending was seen among the middle- and high-income groups, there was a 30.4% post-ACA implementation drop for the lowest-income group and a 21.4% drop for the low-income group.

For middle- and higher-income trauma patients who did not qualify for cost-sharing or premium subsidies, risk may have been raised by the purchase of less comprehensive marketplace plans that exposed them to higher expenses in the event of injury. Some states, such as California, have increased the generosity of subsidies for people to buy marketplace insurance, to enable residents to buy more comprehensive insurance plans.

The authors of the JAMA Network Open study noted that, because Medicaid generally has little or no cost-sharing or premiums, Medicaid enrollment increases “likely contributed to decreases in CHE.”

Other factors in lowering out-of-pocket expenses and CHE risk included:

Marketplace individual insurance plans are required to cover hospital and emergency department care—including trauma—and cap out-of-pocket spending.
The ACA’s establishment of essential health benefits and coverage of pre-existing conditions likely resulted in improved protection.
Improved access to primary care and preventive services potentially could be responsible for fewer comorbidities and complications for trauma patients.

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