

## The Narrative

“As Republicans try to repeal the Affordable Care Act, they should be reminded every day that 36,000 people will die yearly as a result.”<sup>1</sup>

**SENATOR BERNIE SANDERS**

“More people would die if the ACA is repealed than are killed by firearm homicides, HIV, and skin cancer each year.”<sup>2</sup>

**JULIA BELLUZ, VOX.COM**

“The Republican plan to cut Medicare, Medicaid & the ACA will  
... Make America Sick Again.”<sup>3</sup>

**SENATOR CHUCK SCHUMER’S SIGNAGE**

## The Reality

The best statistical estimate for the number of lives saved each year by the Affordable Care Act (ACA) is zero. Certainly, there are individuals who have benefited from various of its provisions. But attempts to claim broader effects on public health or thousands of lives saved rely upon extrapolation from past studies that focus on the value of private health insurance. The ACA, however, has expanded coverage through Medicaid, a public program that, according to several studies, has failed to improve health outcomes for recipients. In fact, public health trends since the implementation of the ACA have **worsened**, with 80,000 more deaths in 2015 than had mortality continued declining during 2014–15 at the rate achieved during 2000–2013.

## Key Findings

- The Affordable Care Act has led to substantial increases in Medicaid enrollment but shows no effect in the aggregate on private insurance coverage; a lower share of non-elderly Americans had private insurance in 2015 than at the start of the recession in 2007–08.
  - ◆ Economic recovery, not the ACA, has driven changes in private insurance coverage: during 2007–10, total employment fell 5.5% and private insurance coverage fell 7.0%; during 2010–15, total employment rose 8.8% and private insurance coverage rose 9.5%.
  - ◆ The share of non-elderly Americans with private health insurance fell from 66.8% in 2007 to 65.6% in 2015.
  - ◆ By contrast, the share of non-elderly Americans enrolled in public insurance, primarily Medicaid, has increased from 18.1% in 2007 to 25.3% in 2015, accounting for the entire reduction in the uninsured share of the population.
- Studies showing positive effects from health-insurance coverage focus on private insurance, not Medicaid.
  - ◆ In Oregon, researchers studied the effects of expanding Medicaid coverage and found no improvement in health outcomes. Numerous other studies support this finding for specific conditions and procedures, for Medicaid expansions and for public health spending generally.
  - ◆ Where studies do find that Medicaid has a positive effect, it is for pregnant women and young children—groups whose coverage was not expanded by the ACA.
- A statistical claim that the ACA saves large numbers of lives should be supported by evidence that it has reduced mortality rates; yet the opposite occurred.
  - ◆ In 2015, age-adjusted mortality rose and life expectancy declined in the United States for the first time since the early 1990s.
  - ◆ Nor is it the case that states adopting the ACA's optional Medicaid expansion performed better than those rejecting it; to the contrary, mortality in 2015 rose more in Medicaid expansion states.
  - ◆ Despite implementation of the ACA, there were 80,000 more deaths in 2015 than had mortality continued to decline during 2014–15 at the same rate as during 2000–2013.

The ACA has had positive effects for specific individuals who have gained access to health care that they may not have had under previous law. By dramatically increasing government spending on health care, it also has relieved financial pressure on beneficiaries of that spending. One might further argue that the promise of coverage has valuable emotional or psychological effects. But defenders of the law make a much stronger claim: that the expansion of health-insurance coverage under the ACA has broad public health benefits and is saving thousands of lives—lives that will be lost in the event of repeal. This is not true.

To support this claim, ACA champions point to studies showing a statistical relationship between health-insurance coverage and declines in mortality. Two studies, in particular, have received significant attention: a 2009 study in the *American Journal of Public Health*<sup>4</sup> that found “[l]ack of health insurance is associated with as many as 44,789 deaths per year in the United States”; and a 2014 study in the *Annals of Internal Medicine*<sup>5</sup> that found “for approximately every 830 adults who gained insurance, there was 1 fewer death per year.”

But these studies focus on private, not public, insurance coverage. The *AJPH* study explicitly excludes Medicaid recipients from its analysis.<sup>6</sup> The *AIM* study examines the effects of the Massachusetts health-care reform in 2006, which primarily expanded private insurance coverage.<sup>7</sup> Thus, both studies suggest that a policy whose effect is to increase private insurance coverage could have substantial public health benefits. The ACA is not that policy.

## How has the Affordable Care Act affected health-insurance coverage?

Evaluation of any policy's effects must begin with the question: *Compared with what?* The ACA was passed as the American economy grappled with the effects of a severe recession and was implemented during the subsequent economic recovery. Thus, while ACA implementation coincides with gains in private insurance coverage, those gains may have occurred anyway, as employment increased.

## On the Record

The practical effect of the Affordable Care Act has been to expand the non-elderly adult population covered by Medicaid. Unfortunately, we know from numerous studies that such Medicaid expansions do not improve public health. Mortality data from the last several years indicate that the ACA has done no better. The best statistical estimate for the net number of lives saved by Obamacare is zero.

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If the ACA were increasing private insurance coverage independent of macroeconomic trends, the number of people with that coverage should have increased relative to the number of people employed. But no such increase occurred. In 2006, at the peak of the last business cycle, there were 1.26 people enrolled in private coverage per person employed.<sup>8</sup> During 2007–10, total employment fell 5.5% and private insurance coverage fell a slightly larger 7.0%; the ratio of coverage to employment was 1.25. During 2010–15, total employment rose 8.8% and private insurance coverage rose a slightly larger 9.5%; by 2015, the ratio was once again 1.25.

Across the entire business cycle, the share of non-elderly Americans with private insurance fell from 66.8% in 2007 to 65.6% in 2015. Some 300,000 fewer Americans had private insurance than might have been expected had the relationship of employment to insurance of 2006–10 held.<sup>9</sup>

Medicaid enrollment, by contrast, has exploded. Whereas 18.1% of the non-elderly population had public insurance coverage in 2006 and 2007, that share had risen to 22.0% by 2010. Rather than dropping as the economy recovered, the share then continued to increase—all the way to 25.3% in 2015.<sup>10</sup> If the share of the non-elderly population with public insurance coverage would have returned to prerecession levels absent the ACA, the law is responsible for almost 20 million new enrollees. If the postrecession level of 2010 represented a “new normal,” the ACA still accounts for an increase of 9 million new enrollees. Either way, with no positive change in private insurance coverage, the Medicaid increases represent the entire gain in insurance coverage.

## What effect does Medicaid have?

Unlike the studies of private insurance that show positive health benefits, numerous studies of Medicaid have concluded that it does not improve health outcomes.<sup>11</sup> Most famously, in Oregon, researchers randomly assigned thousands of prospective Medicaid recipients to either receive or not receive coverage and then followed their health status. They concluded: “This randomized, controlled study showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years.”<sup>12</sup>

The study followed on others that showed patients with Medicaid insurance fared no better than the uninsured—and often significantly worse—for a variety of major surgeries.<sup>13</sup> A study published by Harvard University researchers in the *New England Journal of Medicine* looked for improvements in mortality when several states expanded Medicaid in the 2000s and found, at best, mixed results: New York showed a statistically significant reduction in deaths, Arizona showed a statistically insignificant reduction, and Maine showed a statistically insignificant increase.<sup>14</sup> A more recent study by Raj Chetty and colleagues found, more broadly, that access to health care was not a determinant of life expectancy for individuals in the lowest income quartile.<sup>15</sup>

Where studies have found benefits from Medicaid, the effects appear for coverage given to expectant mothers and young children.<sup>16</sup> That is important information and could provide a strong

argument for ensuring that those groups have access to Medicaid coverage. But once again, the ACA is not that policy.

Under the Children’s Health Insurance Program, created with bipartisan support in 1997, those groups were already eligible for Medicaid or a comparable program at the income levels to which the ACA expanded coverage for other adults.<sup>17</sup> An identical 42.2% of children had public insurance coverage before the ACA’s Medicaid expansion in 2013 and afterward in 2015.<sup>18</sup> The ACA did not create access to health care for them, nor would its repeal eliminate their access.

## What have been the ACA’s results in practice?

If the ACA were, in fact, saving thousands of lives each year, that effect should appear in the nation’s public health data—in particular, in the measures of age-adjusted mortality and life expectancy. But something strange has happened in the past several years during ACA implementation: mortality stopped improving. In 2015, for the first time in decades, American life expectancy decreased.<sup>19</sup>

According to the Centers for Disease Control (CDC), 732 out of every 100,000 Americans died in 2013<sup>20</sup> after adjusting for the changing demographic composition of the country.<sup>21</sup> That figure fell in 2014—as it had fallen in 19 of the prior 20 years—to 725 out of every 100,000. But in 2015, the figure jumped back up to 733; only the second such increase in more than 20 years and the first to erase the prior year’s gains.<sup>22</sup> This represented 30,000 more deaths in 2015 than had the mortality rate remained at the 2014 level; 80,000 more than had it fallen during 2014 and 2015 at the average annual rate of 10.5 per 100,000 seen during 2000–2013.

Perhaps some other phenomenon was responsible for the rise in mortality rates, and so, compared with what *might* have happened, the ACA improved matters. But this does not appear to be the case. Thanks to the split between states that did and did not choose to expand Medicaid under the ACA, a natural control group exists.<sup>23</sup> Did states that embraced the ACA’s Medicaid expansion at least fare better than those that rejected it in this environment of rising mortality? No. In fact, they fared worse: states that expanded Medicaid in 2014 saw mortality increase by nine per 100,000 in 2015 while non-expansion states saw an increase of six per 100,000.<sup>24</sup>

This difference may represent statistical noise rather than a meaningful effect of the ACA. It may also hide confounding factors—perhaps some mortality-raising effect struck expansion states harder than non-expansion states. More broadly, the nationwide mortality increase may be a statistical fluke or the result of other social and epidemiological forces such as the rise in obesity or the opioids crisis.

But if one wants to claim dramatic effects from ambiguous data, a claim that the ACA is killing people would seem at least as defensible as one crediting it with an extraordinary triumph for public health. A more reasonable conclusion for partisans of all stripes to accept is merely that it is not saving lives. In statistical terms, neither the accumulation of past Medicaid studies nor current data can disprove a null hypothesis.

## Endnotes

- <sup>1</sup> Bernie Sanders, Twitter post, Jan. 12, 2017, 11:03 a.m.
- <sup>2</sup> Julia Belluz, "Repealing Obamacare Could Kill More People Each Year than Gun Homicides," *Vox.com*, Feb. 7, 2017.
- <sup>3</sup> Kimberley A. Strassel, "Chuck Schumer's First Fail," *Wall Street Journal*, Jan. 19, 2017.
- <sup>4</sup> Andrew P. Wilper et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (Dec. 2009): 2289–95.
- <sup>5</sup> Benjamin D. Sommers et al., "Changes in Mortality After Massachusetts Health Care Reform," *Annals of Internal Medicine* 160, no. 9 (May 2014): 585–94.
- <sup>6</sup> Wilper et al., "Health Insurance."
- <sup>7</sup> Avik Roy, "Romneycare Improved Health Outcomes, Thanks to Private-Sector Coverage," *Forbes*, The Apothecary, May 7, 2014.
- <sup>8</sup> For health-insurance coverage, see Brian W. Ward et al., "Early Release of Selected Estimates Based on Data from the 2015 National Health Interview Survey," Centers for Disease Control and Prevention, May 2016, table 1.2b (total population inferred from tables 1.1a and 1.1b). For employment, see Bureau of Labor Statistics, Total Nonfarm Employees (annual values calculated as 12-month averages).
- <sup>9</sup> During 2006–10, the average insurance-to-employment ratio was 1.253; see the sources in note 8. Applying that figure to the average 2015 employment of 141.8 million projects total private insurance coverage of 177.7 million. However, the CDC reports total private coverage in 2015 of only 177.4 million.
- <sup>10</sup> Ward et al., "Early Release," table 1.2a.
- <sup>11</sup> See, generally, Oren Cass, "Over-Medicaid-Ed: How Medicaid Distorts and Dilutes America's Safety Net," Manhattan Institute for Policy Research, May 2016.
- <sup>12</sup> Katherine Baicker et al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine* 368 (May 2013): 1713–22.
- <sup>13</sup> Avik Roy, "How Medicaid Fails the Poor," *Encounter Broadside* no. 36 (New York: Encounter, 2013).
- <sup>14</sup> Benjamin D. Sommers et al., "Mortality and Access to Care Among Adults After State Medicaid Expansions," *New England Journal of Medicine* 367 (Sept. 2012): 1025–34, table 2.
- <sup>15</sup> Raj Chetty et al., "The Association Between Income and Life Expectancy in the United States, 2001–2014," *Journal of the American Medical Association* 315, no. 16 (Apr. 2016): 1750–66.
- <sup>16</sup> Aaron E. Carroll, "It's Easy for Obamacare Critics to Overlook the Merits of Medicaid Expansion," *New York Times*, Sept. 26, 2016.
- <sup>17</sup> Kaiser Family Foundation, "Trends in Medicaid Income Eligibility Limits."
- <sup>18</sup> Ward et al., "Early Release," table 1.2a.
- <sup>19</sup> Lenny Bernstein, "U.S. Life Expectancy Declines for the First Time Since 1993," *Washington Post*, Dec. 8, 2016.
- <sup>20</sup> Age-adjusted mortality data for 1999–2015 are available from the CDC's WONDER database: Compressed Mortality, Results by Year. For 1979–98, see "Age-Adjusted Death Rates for 72 Selected Causes by Race and Sex Using Year 2000 Standard Population: United States, 1979–98," Centers for Disease Control and Prevention.
- <sup>21</sup> Age adjustment computes a nationwide mortality rate by applying the mortality rates in narrow age brackets to the distribution of population across ages in the year 2000. This methodology permits apples-to-apples comparisons of public health conditions by preventing the relatively higher death rates among the increasing number of elderly Americans from giving the false impression that public health for persons of a given age is worsening. See Richard J. Klein and Charlotte A. Schoenborn, "Age Adjustment Using the 2000 Projected U.S. Population," *CDC Statistical Notes*, no. 20 (Jan. 2001).
- <sup>22</sup> CDC WONDER database and "Age-Adjusted Death Rates."
- <sup>23</sup> For dates of state Medicaid expansions, see Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision."
- <sup>24</sup> State-specific mortality data are also available from the CDC WONDER database. Aggregate age-adjusted mortality rates across multiple states were calculated by imputing an "age-adjusted deaths" statistic in each state from the total population and the total age-adjusted mortality rate. The aggregate rate was then calculated as the sum of age-adjusted deaths divided by the sum of populations.