ance markets. Monopoly health systems negate insurers' negotiating power over payment rates. Meanwhile, a very dominant insurer makes it extremely difficult for new insurers to enter these markets and negotiate favorable rates with providers. In order to address both types of consolidation, providers could be prohibited from charging more than traditional Medicare payment rates plus a percentage.[3] Medicare Advantage uses a similar policy. Such a policy would counteract the monopoly pricing power of a health system, and insurers could more easily enter new markets, knowing that they would be able to compete using reasonable provider payment rates. As competition increases, premium growth would slow.

An audio interview with Dr. Blumberg is available at NEJM.org

Taken together, these strategies would have significant positive ramifications for patients. Additional outreach and enrollment assistance, reversal of recent administrative impediments to enrollment, and standardization of plans would simplify the enrollment process, facilitating patients' ability to get coverage. Affordability as well as access and continuity of care would be increased through guaranteed and improved premium and cost-sharing assistance. Reduced costs in currently high-priced markets, achieved through a permanent reinsurance program, caps on provider payment rates, and standardized plans, would lead to greater affordability for people who are not eligible for subsidies, and they could increase insurer participation and thus patient choice of insurers and provider networks.

For physicians, more insurance coverage would mean access to more patients who can afford necessary medical care. Lowering premiums, improving cost-sharing subsidies, instituting reinsurance, and increasing outreach and enrollment efforts would lead to large decreases in the uninsured population, with a consequent decrease in the number of people unable to pay doctor bills. The proposed caps on provider payment rates could reduce payments to some providers, but these rates could be set above Medicare rates and still have the desired effect, and they would apply to a market representing just 6% of the population.

Disclosure forms provided by the authors are available at NEJM.org.

From the Urban Institute, Washington, DC.

This article was published on October 18, 2017, at NEJM.org.

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DOI: 10.1056/NEJMp1713247

Lessons from the Latest ACA Battle

Jeanne M. Lambrew, Ph.D.

At the end of the 2017 Obamacare repeal-and-replace legislative battle (and before the next one begins), it is worth taking stock of why — defying the odds — the Affordable Care Act (ACA) still stands. From my perspective as an Obama administration veteran of every near-death experience of the law to date, this one is notable for its unlikely heroes.

Pundits primarily attribute the end of the latest attempt to repeal and replace the ACA to a political failure. With the Republicans in charge of both the White House and Congress, voting to keep the promise of repealing the ACA was, in the words of Senator Chuck Grassley (R-IA), "as much of a reason as the substance of the bill."[1]

The press has also credited the handful of Republican senators who bucked political pressure to oppose four successive repeal-and-replace bills. Senator Susan Collins (R-ME) opposed all the versions, and Senator Lisa Murkowski (R-AK) opposed nearly all of them. Their opposition, unlike the process-oriented objections of Senator John McCain (R-AZ), was grounded in concerns about reducing health insurance coverage, undermining Medicaid, increasing what people pay for health care, and failing to lower underlying health care costs.

But in my experience, "no"

votes cast by a few senators are generally backed by the voluminous work of others. Statements, arguments, and analyses were rapidly provided by consumer groups such as AARP and the American Cancer Society Cancer Action Network, provider groups such as the American Medical Association and American Hospital Association, long-standing coalitions led by organizations like the Center on Budget and Policy Priorities, and new coalitions like Protect Our Care.

In this round, however, with Republican control of the White House and Congress, new and influential actors emerged. Their interventions — which were not cost-free — helped prevent bills that would have reduced coverage and consumer protections from becoming law.

First, the Congressional Budget Office (CBO) and other number crunchers quickly yet credibly punctured politicians' inflated claims about the benefits of the various bills. The CBO produced detailed reports on the cost and coverage implications of eight different repeal-and-replace bills in as many months. Its analysts did so despite personal attacks and threats of budget cuts. Think tanks (e.g., the Brookings Institution, the Commonwealth Fund, the Kaiser Family Foundation, and the Urban Institute) also issued timely quantitative analyses that provided insight into the bills' potential effects in states, on jobs, and for various groups of people. Their basic conclusions were backed by a number of conservative economists and budget experts from organizations such as the American Enterprise Institute — validation that deflected allegations of partisanship. At a time of heightened concern about "fake news," the numbers from the CBO and others powerfully broke through the din to be accepted by policymakers and the public alike.

Second, Republican governors became the unexpected champions of Medicaid. In 2012, the Supreme Court struck down the ACA's requirement that states expand Medicaid to low-income adults, making it an option that 31 states have taken to date. Governors who expanded Medicaid objected to the repeal-and-replace bills that not only ended this option but also capped the traditional Medicaid program. Like senators, governors hold statewide elected office and are powerful voices for their states' residents. Unlike senators, they have their own secretaries of health, Medicaid directors, and budget offices. Governors such as Brian Sandoval (R-NV), John Kasich (R-OH), Charlie Baker (R-MA), and Bill Walker (I-AK) consistently worked with Democratic counterparts led by Governor John Hickenlooper (D-CO) to provide their own critiques of the bills. And half of governors opposed the latest version, the Graham–Cassidy bill, which purported to give them the most control — but put many of them at the greatest financial risk — of all the 2017 bills.[2]

Third, engaged citizens not only expressed their views but took active roles as policy explainers, analysts, judges, and whips. Early in the year, before many members of Congress discontinued them, town hall meetings were packed with people wanting to talk about health care. For example, Jeff Jeans, a cancer survivor and lifelong Republican, asked Representative Paul Ryan (R-WI) why he would repeal the ACA without a replacement. Some concerned mothers brought their children, called the Little Lobbyists, to Capitol Hill to explain how the legislation would limit their own health coverage and care. Twitter became a place for anyone to debate whether and how the evolving policy changed current-law protections and insurance reforms.

Notably, Jimmy Kimmel was given an opportunity to weigh in by Senator Bill Cassidy (R-LA), who began calling the question of whether a bill protects people with preexisting conditions the "Kimmel test." Reviewing the Graham–Cassidy bill through the lens of a father of a child with a major heart defect, Kimmel used his celebrity platform even after critics said his personal views should be left off the field. He defended the right of average people to learn about, explain, and criticize public policy; he was more accurate than Cassidy himself about the Graham–Cassidy bill's content and impact[3]; and he repeatedly told people that if they agreed with his analysis, they should call specific senators (whose phone numbers he provided). These citizens helped break down the walls that kept "laypeople" from being equal partners in this health policy debate and helped close the gap between political support for and public opposition to the legislation.

Finally, past critics of the ACA became effective opponents of its repeal. Insurance commissioners for years complained about the changing ACA rules and the burdens it imposed on states and their insurers. Yet in the end, they became star witnesses at congressional hearings, pointing to the ways the law can be improved rather than replaced. Similarly,

health insurers had been anything but cheerleaders for the ACA. They opposed its passage, chafed during its implementation, and arguably contributed to President Donald Trump's rhetoric about the ACA "exploding." Yet their escalating criticisms of the bills effectively conveyed that the choice is not "repeal-and-replace" or nothing. In the words of the chief executive officer of Kaiser Permanente, "Only a few changes are needed to stabilize the . . . ACA for the millions who are dependent upon the law for their care and coverage."[4]

Indeed, part of the success of these actors rests on the fact that the ACA largely works. More than 90% of Americans are now insured, and people with preexisting conditions have unprecedented access to care. The ACA was carefully designed and implemented to produce results and withstand threats — although as President Barack Obama said repeatedly, it can and should be improved.[5] Ideas such as increasing financial support for high-cost patients, lowering spending through value-based payments, and streamlining state waiver processes have bipartisan congressional and gubernatorial support — as does responding to the Trump administration's unilateral reduction in ACA funding. It is not yet clear whether the Republican Congress and White House will embrace improvements or return to attempts to repeal the law.

In the 6 years that followed the ACA's enactment, Obama blocked the passage of repeal-and-replace bills. In the seventh year, when he no longer held the veto pen, that task fell to others. Indeed, it may be that Obama's desired legacy of citizen engagement has saved his legislative legacy — the ACA. Understanding the role of citizens along with those of others is important in case the repeal bills return. It may also provide lessons for other battles over policy in an era of single-party control.

Disclosure forms provided by the author are available at NEJM.org.

From the Century Foundation, New York.

This article was published on October 18, 2017, at NEJM.org.

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DOI: 10.1056/NEJMp1712948

My Real Patients

Lisa Simon, D.M.D.

At the end of the first semester of medical school, we were each assigned a time slot to spend with a standardized patient — an actor portraying a sick person — in a mock clinical encounter. A preceptor would monitor the interaction and let us know how we could improve our history-taking, physical exam, and communication skills.

The encounters are intended to be as true to life as possible. They take place in rooms that look just like any other outpatient clinic, with an otoscope on the wall and an exam table in the corner. But they also have one-way mirrors, multiple computer screens, and listening stations with headphones for our preceptors, as if they are detectives on a stakeout. The encounters are digitally recorded from two camera angles so we can watch them later.

All week, I am a medical student. But on Thursday evenings, I still work as a dentist at the city jail. The patients I see are always suffering. They usually didn't have access to a dentist before becoming incarcerated or experiences with a dentist — or any medical provider — whom they trusted. Building a good relationship from this sterile ground is the part of my job, and my identity, that I cherish. As a result, I wasn't feeling worried about the communication skills that this mock encounter was supposed to evaluate. After all, though my real patients