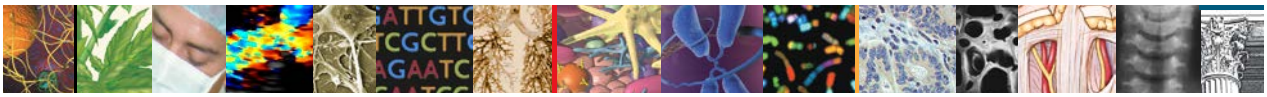

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Perspective

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Here to Stay — Beyond the Rough Launch of the ACA

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Open enrollment for 2014 insurance coverage under the Affordable Care Act (ACA) ended on March 31. When the White House reported that enrollment had reached the targets, one could almost hear sighs of relief from supporters and gnashing of teeth by opponents. In truth, meeting the enrollment targets made clear only that the administration had successfully brought order out of the chaos attending the rollout last October. After a ritually correct interval, Kathleen Sebelius, head of the cabinet department immediately responsible for that chaos, resigned.

Meeting numeric targets that were measured 6 months after the insurance exchanges opened will not determine the fate of the ACA. With time and administrative care, the ACA can and, I believe, will be implemented successfully. For the next several years, however, brutal political war, not objective measures, will determine the law's fate. Over the longer term, the ACA's success will depend on elected officials' responses to the challenges that emerge as the U.S. health care system evolves.

Most features of the ACA derive from one binding constraint: it had to be an incremental plan. Neither of the major competing visions for transforming the U.S. health insurance system was politically viable. The conservative vision — to provide people with vouchers to help them buy insurance individually in a competitive private market — was unacceptable to the Democratic congressional majority and to President Barack Obama. The liberal vision — Medicare-for-all or some other variant of a single-payer system — had never appealed to more than a minority in Congress, a reality that led the pragmatic leader of Senate liberals, Massachusetts' Edward Kennedy, to abandon it.

Even more important was the public's transparent lack of trust that a politically riven Congress could get radical reform right. Most Americans were well insured and generally satisfied with their own coverage. To be sure, they recognized that health care costs were rising too fast and that too many people were uninsured, but most were happy with their doctors and their last hospital experience and feared that radical change would jeopardize protection they valued highly.

That satisfaction and resistance to change were the reasons that

the President promised the American public that those who liked their insurance could keep it. Though much criticized, that promise expressed the indisputable truth that the ACA was crafted to leave in place as much as possible of the preexisting system of health insurance.

The problem was — and is — that this decision meant that reform had to be built on the most complex, kludgy, and costly system on planet Earth. Multiple layers of health coverage — as a fringe benefit of private employment, as compensation for military service, as public charity for the poor, as public coverage for the elderly and disabled, and as a private commodity purchased by individuals in a remarkably dysfunctional market — overlap and intersect to pay for care through a bewildering variety of agents in a system that even experts seldom fully comprehend.

A reform built on that system could not escape its complexity. Most employers had to maintain or expand coverage — hence the employer mandate. Most people who lacked coverage through work or a public program had to become insured — hence the individual mandate and the Medicaid extensions. Making all insurance adequate and available required insurance-market reforms. Making insurance affordable required the refundable tax credits provided through the exchanges. The law came to include much more, but these core elements account for its complexity.

ACA enactment did not end political infighting, which continued in the elections of 2010 and 2012. The botched administrative rollout in October 2013 reinforced the determination of ACA opponents to continue the fight. Should the 2014 elections shift control of the Senate to the party that opposed the law, the political wars will surely continue at least through the 2016 presidential election.

Although some opponents continue to call for repeal of the ACA, the law is here to stay. As long as Obama remains in office, he would surely veto any repeal law, and a veto override is inconceivable. Come 2017, outright repeal will remain unlikely for three reasons. First, all major parts of the ACA except the individual mandate are popular — including the insurance-market reforms, the subsidies to make insurance affordable, closure of the drug-benefit "doughnut hole," and the incentives for most employers to provide affordable insurance as a fringe benefit. Second, lawmakers who support repeal will not want to snatch insurance coverage from an estimated 37 million people who will be insured thanks to the ACA in 2017.[1] Third, repeal would cut into the sales and profits of health care providers and suppliers of all stripes.

Although repeal of the ACA is therefore unlikely, amendments are certain. If ACA opponents win control of Congress and the presidency, they will probably try to scale it back. The proposal of Republican Senators Richard Burr (NC), Tom Coburn (OK), and Orrin Hatch (UT) is indicative of the likely direction for such legislation. Although labeled as "repeal and replacement," it would actually scale back the ACA while retaining some of its framework. It would cut affordability subsidies and weaken the penalties for people who remain uninsured. It would also cap Medicaid spending, regardless of increases in health care costs. Other changes, well short of repeal, may also emerge. For example, Congress, which long ago gave states the right to regulate insurance, could authorize each state to curtail or reject certain elements of the ACA.

If ACA supporters prevail in 2016, some desirable and overdue technical changes may become feasible. For example, the law requires people to carry health insurance only if it is affordable. If worker premiums for adequate employer-sponsored coverage cost less than 9.5% of household income, insurance is deemed "affordable." Employed workers with an offer of such affordable coverage do not qualify for tax credits through the health insurance exchanges. The administration found, to its dismay, that the law bases affordability on the premium for single-worker coverage, even for workers with dependents whose premiums are higher. The fix for this obvious flaw is simple. But a blocking congressional minority refuses to allow any change in the ACA other than complete repeal.

Other changes, some not yet widely understood, will come to be seen as desirable. Households qualify for refundable tax credits to help make insurance affordable on the basis of current or expected income. Those subsidies are paid directly to their insurers. People whose annual income turns out to be lower than it was expected to be when they applied for tax-credit assistance will receive a refund on their next year's tax return. But people who get a raise or a better-paying job must recompute the tax credit on the basis of their total annual income and pay back any excess as much

as a year or more after it was paid, not to them, but to a third party — the insurance company. This cumbersome and politically fraught procedure results from placing administrative responsibility for computing, paying, and adjusting subsidies with the Internal Revenue Service, an organization that operates exclusively on an annual accounting period. No other program designed to help people meet specific needs — food, housing, or health care (Medicaid) — tries to recompute need well after the end of the period when financial aid was given. Correcting this mistake, though difficult, is straightforward. But it can be addressed only when the ACA is recognized as here to stay, by both those who fought for and those who fought against its passage.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act. Washington, DC: Congressional Budget Office, April 2014.

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Health Care Reform after the ACA

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After a shockingly bad start, the Affordable Care Act (ACA) has completed its first open-enrollment season. As many as 8 million people have selected health plans through the federal and state insurance exchanges, and perhaps another 3 million have enrolled in Medicaid and the Children's Health Insurance Program. ACA supporters have breathed a sigh of relief after several months of calamitous problems with the enrollment process.

Nevertheless, the ACA is far from successful. To defuse problems that jeopardized the reform, the Obama administration has deviated substantially from the legislative blueprint enacted in 2010. Deadlines have been delayed and requirements have been changed as it became clear that they were infeasible or highly inconvenient. The next few years will see further changes as the administration — possibly with the help of Congress — accepts that major ACA provisions simply do not work.

Though such adjustments might smooth out some rough edges, they will not change the structure of the reform law, which uses the language of competition and consumer choice but relies heavily on regulation to tightly limit the functioning of the market. Although the administration may delay enforcing or attempt to moderate some less-popular provisions, that won't significantly alter the path we are now on.

Conservative opposition to the ACA centers on two related concerns: cost and control. Rising U.S. health care costs have long been a problem, imposing a growing burden on families, businesses, and governments. The ACA creates new subsidies for insurance purchased on the exchanges and expands Medicaid eligibility, increasing the pressure from entitlements on state and federal budgets. Subsidies shift the burden but do not reduce the cost.

The ACA does not address more fundamental reforms of the financing system that could slow the growth of spending and improve the value that consumers receive.[1] Instead, it relies on tighter federal regulation to limit what can be sold on the insurance market and requires everyone to buy insurance. Conservatives fear that the judgments of experts or bureaucrats will determine how we spend our health care dollars even though consumers might not agree with those judgments.

Republican policymakers have proposed health care reforms aiming to lower costs, expand choice, and protect the vulnerable,[2] although political realities have constrained the policy options they've advanced.[3] A comprehensive reform proposal founded on conservative market principles would address several realities.[4]

First, shifting from the system of uncapped federal subsidies for health care to a defined-contribution approach, with coverage provided through competing plans, would change the financial incentives that promote unnecessary and wasteful spending. That would mean implementing premium support in Medicare, with the traditional fee-for-service program competing on an equal basis with Medicare Advantage