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The Future of the Affordable Care Act Reassessment and Revision

Stuart M. Butler, PhD, MA

In this issue of JAMA, President Barack Obama describes many of the features and highlights the results of the Affordable Care Act (ACA).¹ Aligning federal payments more with demon-



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strated value and encouraging a move away from a fee-for-service model to managed care has helped reinforce or change the type of reimbursement patterns in the private sector. Allowing young adults to remain on their parents' insurance plan and curbing preexisting condition exclusions addressed significant problems. Creating exchanges was a key step toward allowing US residents to keep the health coverage they want as they move from job to job. Moreover, significantly reducing the number of uninsured households has brought improved care and a measure of financial security to millions of Americans.

However, in looking ahead and thinking about next steps, it is also important to recognize some troubling trends in the ACA that the president has not adequately discussed.

For example, the ACA might be more appropriately labeled the "Medicaid Expansion Act." Although the Congressional Budget Office (CBO) confirmed in March 2016 that there has been a large reduction in the number of uninsured individuals, the sources of coverage are significantly different from its expectations when the law was in the process of enactment.² Medicaid and the Children's Health Insurance Program (CHIP) will cover an estimated 17 million more people in 2016 than the CBO's earlier assessment. On the other hand, enrollment in the ACA exchanges has been disappointing, with an estimated 10 million fewer people enrolled compared with ear-

lier projections. Last year, Department of Health and Human Services Secretary Sylvia Burwell announced a sharply reduced goal for growth in exchange coverage in 2016: just 1.3 million compared with much higher earlier projections.³ Moreover, the CBO now estimates that over the next 10 years, as the population increases, the number of people with coverage will expand only modestly, and the proportion of individuals uninsured will cease to decline.²

A cause of the disappointing trend in exchange enrollment and the strong Medicaid growth is that the premiums and out-of-pocket exposure make exchange plans unattractive to many US residents. With subsidies focused on people with incomes near the poverty line, many middle class and modest-income households find they face substantial and uncertain costs if they enroll in exchange plans. Those choosing bronze plans to keep premiums low essentially have only catastrophic coverage. While that is an improvement over being uninsured, for many it is coverage in name only. For many households, the president's promise of affordable coverage rings hollow and has not been realized.

The president is also unduly sanguine about the future of health care costs. Financing of Medicare has benefited from a slowdown in the increase in health costs. But this trend preceded enactment of the ACA, and many analysts are uncertain about the cause and continuation of the slowdown in the growth of health care costs, attributing much of the moderation to the Great Recession.^{4,5} The president could be correct that the ACA will slow the growth of per capita health spending, but the CBO and others expect spending to increase more rapidly in the future.⁶ In addition, the political future of the excise tax on expensive health plans offered through the

workplace (the so-called Cadillac tax) is uncertain because of bipartisan opposition in Congress and from business and labor leaders. However, the tax is needed, not just for revenue purposes to help pay for the ACA, but also to exert downward pressure on the cost of employer-sponsored insurance. Without this tax, the great majority of health economists are concerned that an important incentive to hold down costs will disappear. Widespread political resistance to using the Independent Payment Advisory Board (IPAB), designed to limit future Medicare spending, should also be concerning for the president.

In looking ahead and building on the progress he sees under the ACA, the president seems content with making tweaks to the design of the ACA rather than revisiting the design of some of its fundamental aspects. But several features do need rethinking.

First, the system of subsidies must be revised to make coverage more affordable and the subsidies simpler to understand and use. In addition to addressing the “family glitch” (ie, the legislative drafting ambiguity that excludes many working families from exchange tax credits), Congress needs to address both the large out-of-pocket cost exposure facing many families and the inadequate subsidies available to moderate-income families. While the subsidy system should continue to be income-related, it must make coverage affordable to both households and taxpayers. That will be no easy task. Subsidies were limited to lower-income households in part to keep down the considerable cost of the ACA. Moreover, the flat credit approach favored by most Republicans as an alternative to the ACA’s structure would mean that sicker and poorer households will continue to face substantial cost without a degree of insurance regulation that Republicans would abhor and oppose.

Second, although the Cadillac tax is an inelegant compromise, and it is better than nothing, its political tribulations suggest that it might be wiser to confront the underlying problem, which is the tax exclusion available to employees for employer-sponsored insurance. Almost all health economists agree that excluding all compensation devoted to health coverage is regressive and inefficient and discourages cost consciousness. Most economists would partially or completely replace the exclusion with a refundable tax credit related to income and health costs. A first step would be to modify the Cadillac tax such that the excess plan cost above a cap becomes taxable compensation for the employee rather than an amount subject to an excise tax. That change would begin to introduce progressivity while encouraging greater cost consciousness at all income levels.

Third, a more aggressive approach to foster federalism within the health system is needed. This includes making maximum use of section 1332 of the ACA—which takes effect in 2017. This section allows states to apply for waivers from many core features of the ACA, such as the exchanges and the law’s employer and individual mandates, to pursue other ways of meeting the coverage goals while retaining the basic protections of the ACA. The Obama Administration’s record on using the federalism tools it has are mixed, and that might explain the absence of any discussion of federalism in the

president’s article. It is true that this administration has used its Medicaid waiver authority to launch some bold and potentially far-reaching experiments and to encourage some conservative states to agree to expand Medicaid under the ACA. But the administration has done little to allow states to make use of the extensive waiver authority permitted under section 1332. That has been a serious mistake. The section permits states to pursue the ACA’s objectives in a wide variety of ways. By encouraging use of the provision, the administration could have traded control over the details of ACA implementation for a much broader political commitment among states to achieving the broad goals of the law. But instead, the administration has been slow to give clear guidance to states and thus has discouraged many from offering proposals.

Fourth, the pattern of lackluster enrollment in exchange plans amid the expansion of traditional Medicaid needs to be reversed, with the exchanges viewed as ultimately the primary vehicle through which Americans obtain personalized health insurance. In particular, this and future administrations need to be more open to states turning Medicaid for working households into a “private option” that is a subsidy for purchasing private plans on the exchanges. Moreover, if the subsidy structure for exchange plans and the tax treatments of employer-sponsored insurance can be made equivalent, it would become more attractive for employees to obtain coverage through the exchanges, allowing them to have greater choice and more portable coverage.

Fifth, Congress should replace the IPAB with a premium support system for Medicare. The purpose of IPAB is to enforce a long-term budget for Medicare. But rather than do so by imposing payment and price controls, which are the only tools available under law to the IPAB, a premium support approach would achieve the same budget objective while placing greater control over the use of funds into the hands of Medicare beneficiaries. That would help accelerate innovation in the design and pricing of Medicare services, including the expansion of Medicare Advantage Plans.

Sixth, the ACA should be seen as a step toward promoting health rather than simply making health services and insurance more readily available. The health sector increasingly recognizes that it should focus more on “upstream” determinants of health, not just on medical services. The Obama Administration can take some credit for helping to encourage this adjustment of focus. Through waivers, requirements on nonprofit hospitals to review community health conditions, and pilots launched by the ACA-created Center for Medicare and Medicaid Innovation, the administration has helped persuade the health care sector to explore social determinants of health. It has also begun to encourage different federal agencies to cooperate on experiments to improve health, such as revamping housing services to reduce the need for costly long-term care. In the future, it will be essential to find more ways of blending health, housing, transportation, social services, and other budget streams to improve health while reducing the need for costly medical services.

In pondering lessons to be drawn from the ACA experience, the president predictably criticizes partisanship and

special interests. But he also stresses the lesson of appreciating pragmatism in legislation and implementation. That is a good lesson, yet it does not contradict the importance of also being guided by philosophical principle. If it were a separate economy, the US health system would be equivalent to the fifth or sixth largest economy in the world. It is both pragmatic and

principled to recognize that achieving agreement on how to redesign an economy that large, or to do it successfully in 1 piece of legislation, is beyond the capabilities of the federal government. That is why core parts of the ACA need to be reassessed and revised and why empowering the US system of federalism to adapt and experiment with the law is so important.

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The Past and Future of the Affordable Care Act

Jonathan Skinner, PhD; Amitabh Chandra, PhD

In this issue of JAMA, President Barack Obama has provided a comprehensive assessment of the Affordable Care Act (ACA),¹ which as he indicates is the most comprehensive health care



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reform since Medicare. In 1965, Medicare passed in the House with a 313-115 vote and in the Senate with a 68-21 vote. By contrast, the ACA barely reached the filibuster-proof threshold of 60 votes in the Senate and passed the House with a 219-212 vote. As President Obama has chronicled, that the ACA passed at all, let alone survived multiple Supreme Court and Congressional challenges, is a political miracle.

Despite these compromises and partial setbacks, the primary goal of the ACA has been met: to expand the number of people with health insurance. With an estimated expansion in health insurance of 20 million individuals, President Obama is right to claim credit for the ACA. But counting up the number of individuals with insurance is not enough to assess if the ACA was a success. Perhaps the more important measures are whether the ACA improved health and saved money. For example, the 2008 Oregon Health Insurance Experiment, a randomized trial of Medicaid expansion, found that newly insured individuals used more hospital care, were given more prescription drugs, and received more preventive care than before receiving insurance. Individuals were less likely to be diagnosed with depression and experienced less medical debt, a leading source of bankruptcy. Although almost everyone reported being able to see a physician, hypertension and diabetes control did not change relative to the control group, overall medical spending increased

by \$1000 per person annually, and emergency department use increased by 40%.^{2,3}

These findings from Oregon, in contrast to claims that were made to justify the ACA,⁴ suggest both optimism and caution for the ACA's primary goal of expanding insurance coverage and the related consequences. Even Medicaid—an insurance program that offers lower payment rates and narrower networks than commercial insurers and Medicare—is valuable but possibly less valuable than had been hoped. In other words, providing health insurance may not automatically result in an improvement in health when health care systems are fragmented and inefficient.

A central feature of the ACA has been the accountable care organization (ACO), the goals of which were to reduce fragmentation and inefficiency by encouraging the innovative redesign of primary health care, measuring health outcomes, and relying on physician-led expert systems and treatment pathways. Many ACOs have proven to be successful in achieving improvements in health process measures, timely access to physicians, and overall patient satisfaction.^{5,6} Among the challenges facing current ACOs are that some of these organizations do not know their cost structure, have little control over loosely affiliated physicians, and are prohibited from implementing patient cost-sharing for unwarranted treatments. Yet the continued growth of ACO contracts, even in commercial markets, suggests continued optimism by both health care organizations and health care professionals, as well as by insurance companies for this new organizational structure.

A second key objective of the ACA was to make health care affordable. President Obama's Special Communication reports