

## VIEWPOINT

# The Affordable Care Act

## Moving Forward in the Coming Years

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Viewpoint page 21

**President Barack Obama** signed the Affordable Care Act (ACA) in 2010 with no Republican support. The ACA has been politically divisive ever since, with the House repeatedly voting for repeal. Earlier this year, Congress successfully passed a repeal, with the Senate using a legislative process called "reconciliation," which requires only a simple majority for certain tax and spending bills to pass. However, Congress failed to override a presidential veto.

President-elect Donald Trump pledged to "repeal and replace" the ACA but would keep the most popular features: (1) guaranteed issue—health plans must enroll applicants regardless of preexisting conditions; and (2) dependent coverage—health plans must keep dependent children on their parents' plan until age 26. Although his reform package has not been announced, it will likely include health savings accounts (HSAs), cross-state insurance sales, Medicaid block grants to states, and a cap on noneconomic damages.

### ACA Design Features

The principal aim of the ACA was to improve access to health insurance, including expanded Medicaid eligibility, an individual mandate, and subsidies for low-income enrollees. The Supreme Court upheld the

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individual mandate but allowed states to opt out of the Medicaid expansion.<sup>1</sup> Currently, 19 states have declined to expand Medicaid eligibility.

To stabilize insurance markets, the ACA established exchanges or "marketplaces" where individuals could shop for insurance. To reduce cost and improve quality, the ACA encouraged the creation of accountable care organizations, whereby health care professionals and hospitals would offer coordinated high-quality care to Medicare beneficiaries. To pay for reforms, the ACA taxed medical devices and high-benefit plans, while decreasing Medicare spending.

The law drew criticism in 2014, when the website [healthcare.gov](http://healthcare.gov) failed on launch. More recently, consumers have expressed concern about narrow networks, high deductibles, and premium spikes. The individual mandate has not been sufficiently effective at getting healthy individuals to enroll, and some major insurers have withdrawn from exchanges. Nonetheless, the ACA has considerably expanded access, with more than 20 million individuals gaining coverage—60%

through Medicaid. The effects of the ACA on quality and cost are less clear.

### Repeal and Replace

Beyond the 4 reforms discussed below, the House leadership's "A Better Way" also proposed refundable tax credits (replacing exchange-based subsidies); high-risk pools for individuals with chronic disease; continuous coverage protection; capping the tax benefit on employer-based plans; and association health plans to pool small businesses' purchasing power.<sup>2</sup>

### Health Savings Accounts

HSAs are employer-sponsored, tax-advantaged accounts that employees use to pay out-of-pocket health care expenses. HSAs are funded through pretax employer/employee contributions. Unlike flexible spending accounts, unspent HSA funds roll over to subsequent years. HSAs are paired with high-deductible insurance policies, with annual out-of-pocket expenses capped.

HSAs are popular, with 24% of all workers enrolled during 2015—a major increase compared with 8% in 2009.<sup>2</sup> Federal tax records show that 6 million households made pretax HSA contributions.<sup>3</sup> HSA enrollees have lower health care spending but may economize by reducing necessary care.<sup>4</sup> Many HSA enrollees are also unaware that preventive care may be obtained without a co-payment.<sup>5</sup> In addition, HSA tax incentives are much less valuable to lower-income employees.

Consequently, HSAs are unlikely to materially expand access. Another concern is that HSAs could further fragment risk pools by disproportionately attracting younger, healthier individuals.

### Cross-State Insurance

Interstate competition can disrupt intrastate monopolies and force states to reconsider the costs imposed by insurance regulations. Cross-border sales of health insurance policies could ease regulatory burdens and widen consumer choice. Theoretically, states with high levels of regulation would lose business to states with less strict regulations. Potential benefits of increased competition, however, could be offset if states could not effectively regulate out-of-state health insurers. For example, states could not require companies to provide minimal benefits and might encounter difficulties protecting residents from fraudulent policies.

Although considerable variation among the states remains, the ACA set a federal floor for many health insurance benefits. More importantly, health care delivery

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is quintessentially a local business—meaning insurers must construct networks desirable to enrollees. Illinois residents, for example, might be attracted to a less-expensive South Dakota plan, until they realize in-network health organizations and health care professionals are primarily in South Dakota. Insurers could become more “local” by building new networks or renting from other insurers. Yet structural barriers impede out-of-state insurers from forming competitive networks. Moreover, self-funded employment-based coverage is already insulated from state-level mandates. In combination, these dynamics mean the savings from sales across state borders will be relatively modest.

#### Medicaid Block Grants

Block grants allocate federal funds to states, giving them considerable discretion to tailor their Medicaid program to meet the preferences and health needs of their residents. Block grants incentivize states to become “laboratories of democracy,” with innovative ideas diffusing to other states.

As a fiscal tool, block grants cap the federal government’s exposure, requiring states to pay the full cost of more generous benefits. This particularly disadvantages states with higher costs per beneficiary and larger Medicaid populations, such as California and New York. Overall, block grants would probably reduce Medicaid eligibility and lower benefits, as states try to save taxpayer dollars. States might also tie Medicaid coverage to personal responsibility requirements and impose co-payments—both of which are politically contentious.

#### Noneconomic Damage Caps

Tort reform has become a popular response to medical malpractice litigation, beginning with California’s 1975 cap on noneconomic damages. Currently, more than 30 states have caps on noneconomic damages, total damages, or both. Tort reform is perceived to reduce defensive medicine, thus lowering health care spending. Yet, the extant evidence does not support these claims. Although an early study found that malpractice reforms were associated with reduced Medicare spending,<sup>6</sup> more recent studies have found much smaller or no effects.<sup>7</sup> Even if damage caps actually reduced spend-

ing, a federal cap would have to be substantially lower than current state caps to generate significant nationwide savings.

#### Politics and Popularity

Social welfare legislation is inherently political, and the absence of bipartisan support during passage of the ACA hardened party-line opinions. The Senate also used reconciliation to adopt the ACA, further fueling Republican discontent. Although the public approves of individual provisions in the ACA, the law as a whole generally remains unpopular.

If “repeal and replace” passed on a party-line basis, it could generate the same dynamic that undermined the ACA. There are also legal impediments to using the reconciliation tool for nonbudgetary aspects of the reform package. Moreover, if Congress were to remove subsidies or benefits that individuals now enjoy, it could provoke a political backlash. In particular, repeal of the ACA risks losing the coverage gains that have occurred since passage of the act, unless new legislation provides an adequate substitute. Repeal also risks eliminating the demonstration projects, many supported by the Center for Medicare & Medicaid Innovation, that can help determine effective alternative payment models.

Retaining guaranteed coverage for those with preexisting conditions would likely destabilize the insurance market unless there were a robust individual mandate, or some other means to ensure that younger and healthier individuals buy coverage. Failure to ensure a sustainable risk pool could trigger a “death spiral” in the individual and small business insurance markets.

Empirical evidence, no matter how persuasive, is filtered through a political lens. Yet the values of access, quality, and cost savings should be broadly shared across the political aisle. There remains a wide ideological gap in how to achieve these social goals. The public, however, has a right to expect their representatives to find common ground and adopt evidence-based policies that expand coverage at a reasonable cost. The goal should be to ensure that all individuals—sick or healthy, poor or well-off—receive the care they need. Finding innovative, market-based solutions to expand risk pools and lower insurance premiums, while also providing a robust social safety net, deserves bipartisan action.

#### ARTICLE INFORMATION

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