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.

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From the Brookings Institution, Washington, DC.

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Health Care Reform after the ACA

Joseph R. Antos, Ph.D.

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

plans, and a block-grant program for Medicaid, with fixed payments to states replacing unlimited matching payments. In addition, to promote a more competitive insurance marketplace, the tax treatment of health insurance could be reformed: a refundable credit available to everyone would be more equitable than the tax exclusion for employer-sponsored coverage and the "Cadillac tax" on the most expensive health plans, and it would eliminate the current bias in favor of employer coverage.

Second, access to health insurance regardless of preexisting conditions can be ensured without the highly unpopular mandate for individuals to buy coverage. The mandate can be replaced by the sort of protection already available to workers under the 1996 Health Insurance Portability and Accountability Act. That would mean guaranteeing that everyone who remains insured without a break in coverage could not be charged higher premiums or have their benefits restricted because of a preexisting condition. Moves among insurance plans would be protected as long as an individual maintained at least catastrophic coverage. Those who did not would be subject to medical underwriting, with higher premiums related to their current level of health risk.

To make this a feasible business proposition for insurers, well-funded high-risk pools would be needed for people with extremely high costs, allowing them to purchase insurance at reasonable rates without driving up premium costs for everyone else and driving healthier people out of the market. The ACA created temporary high-risk pools that quickly exhausted their $5 billion funding; permanent replacements would probably require $15 billion to $20 billion in public funding annually.[5]

Third, the ACA failed to enact meaningful Medicare and Medicaid reforms. The substantial reductions in Medicare provider payments produced savings to offset the cost of insurance expansion but will probably be overturned by future Congresses. Other provisions, including accountable care organizations and bundled-payment pilot projects, might eventually improve Medicare's performance. Missing are reforms that engage Medicare beneficiaries as active consumers. As the Part D experience demonstrates, seniors can be smart shoppers if given appropriate financial incentives and information about options.

Medicaid suffers from an overly ambitious agenda, poor incentives that discourage system improvements, too many masters, and below-market provider-payment rates that often result in severely restricted access to care. States should focus on better achievement of Medicaid's core mission of helping the neediest Americans before expanding to additional populations. In addition, Medicaid's management could be improved through a block-grant approach, which would let states keep all the savings achieved through cost-cutting measures and remove the disincentive inherent in the matching-payment system, and would allow states greater authority to make program changes without waiting months for federal approval.

Finally, some changes unrelated to financing are needed. More work is needed to develop reliable information, the lifeblood of any market-oriented reform: consumers need better information about health plan choices, and patients and physicians need better information about clinical options. If we fail to change care delivery, we face a shortage of primary care physicians; we need greater reliance on nurses and other medical professionals working in teams, greater use of telemedicine, and a shift to retail malls and other nontraditional settings. The Choosing Wisely campaign is a promising sign that the medical profession can refine standards of care in light of realistic budget constraints.

The question facing the Obama administration is what parts of the ACA can be made to work and what parts must be jettisoned. The appointment of Sylvia Mathews Burwell as secretary of health and human services indicates a shift of emphasis from selling the hope of health care reform to managing its gritty reality.

It is increasingly likely that the administration will drop enforcement of the individual mandate. The mandate's penalty is supposed to be levied on individuals who go without coverage for 3 months, but the federal exchange was still enrolling people in April, and one has only to claim an unspecified hardship to be exempted from the penalty. Moreover, political fallout would be severe if the Internal Revenue Service tried to withhold tax refunds from low-income families.

Other major provisions are up for grabs. The employer mandate was delayed, and the idea of defining full-time work as 30 hours per week has lost support among congressional Democrats. To allow some people to keep their

old plans, insurance rules will not be enforced for the next few years. The contention that "risk corridors" — which limit insurers' potential gains and losses in a risk-sharing arrangement — amount to an insurer bailout has caused some rethinking in the administration.

If Republicans gain a Senate majority in the fall, they will have an opportunity to negotiate entitlement reforms. They will continue to demand Obamacare's repeal, but they'll probably have more traction reforming Medicare than making major changes to the President's most personal political achievement.

Yet Republicans can be expected to advance targeted proposals to eliminate the ACA's most unpopular and unworkable aspects and substitute market-based alternatives. Such proposals will embrace the possibility of a more decentralized, less regulatory, and more consumer-driven model of health care. I believe that will be the direction of the next phase of health care reform in 2017, no matter who is elected President.

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The "Doc Fix" — Another Missed Opportunity

Stuart Guterman, M.A.

On April 1, 2014, President Barack Obama signed into law the Protecting Access to Medicare Act of 2014, averting the 24% across-the-board reduction in Medicare's physician fees mandated by the sustainable growth rate formula (SGR) used to set those fees each year.[1] This action provides relief to physicians, who would have faced a substantial reduction in Medicare revenues, and to beneficiaries, who would have faced potential disruption of access to needed care. That relief, however, is only temporary — this was the 17th time since 2002 that Congress has temporarily overridden SGR-mandated cuts — and the move represents a missed opportunity to permanently eliminate the SGR, an ongoing impediment to the alignment of payment incentives with health system goals.

In place since 1998, the SGR was designed to adjust the annual increase in Medicare fees on the basis of the cumulative level of physician spending relative to overall economic growth. The rationale was that since fee-for-service payment rewards the provision of more services and more invasive and expensive services, some mechanism was necessary to counter the tendency toward spending growth driven by increases in volume and intensity.

In its first few years, with the rapid economic growth of the late 1990s, the SGR produced relatively large increases in Medicare's physician fees.[2] As the economy slowed in the early 2000s, however, while physician spending continued to increase, the formula began to dictate reductions in those fees. Those cuts would have applied to every service, regardless of its potential benefit (or lack thereof), and to every physician (or other health care professional paid under Medicare's physician fee schedule), regardless of his or her own contribution to spending growth. In addition, the threat of a widening gap between physician fees paid by Medicare and those paid by private insurers raised concerns about preserving beneficiaries' access to care.

The SGR fails to address volume and intensity — the factors driving Medicare spending growth — directly, and its across-the-