EDITORIAL

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 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.

Editorial

Related article

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 substantially slower increases in health care spending during the first 5 years of the ACA (2010-2014).[1] One question is whether this slowing occurred because of the ACA, or because of other factors unrelated to the ACA, such as the long-lasting effects of the recession, or the increase in amounts of deductibles and copays.

It seems unlikely that, at least for the period 2010-2014, the ACA can claim much credit for the slowdown in the increase in spending growth. The slowing of health care spending began in 2006, before both the ACA was passed and the onset of the 2008 recession. A previous study suggested that the specific cost-saving components of the ACA during this period could not have accounted for this moderation in growth.[7] For example, even though ACOs have been expanding rapidly in recent years, their short-term effect on cost growth has been modest, with estimates generally less than 3%.[8,9]

So if not the ACA, why was inflation-adjusted Medicare spending declining on a per-capita basis during 2010-2014? During the recession, Medicare enrollees were insulated from higher copayments and deductibles, and faced neither employment risk nor loss of health insurance. Instead, the early enthusiasm for many then-new technologies developed in the 1990s and 2000s ebbed beginning in 2006, leading to a general "exnovation" or scaling back of many common and expensive treatments such as coronary artery bypass graft surgery, carotid endarterectomy, coronary artery stenting, and inpatient back surgery.[7]

The ACA does support the growth of some new technologies that have uncertain benefits. For example, proton beam therapy for prostate cancer has diffused rapidly in recent years because of generous reimbursement by Medicare and private insurance.[7] Medicare's coverage generosity, especially for treatments that are physician-administered or given in an outpatient setting, influences coverage decisions made by commercial insurers and care delivered to patients in Medicare ACOs. This is especially true in the area of pharmaceuticals, where Medicare is pressured to pay for any cancer treatment in an approved compendium.

In part because of these newer technologies, health care costs have increased substantially in recent years. According to data from the Altarum Institute, between March 2014 and March 2016, inflation-adjusted health care spending increased by 8.1%, nearly double the 4.1% growth in gross domestic product.[10] Because of this rapid growth rate in health care spending, Altarum estimates that the share of gross domestic product devoted to health care has also increased, from 17.3% in March 2014 to a record 18.1% in March 2016.[10] Little of this increase during the past several years has been because of health care prices, which have increased at about the same rate as prices overall,[11] but rather, the increase in health care spending reflects greater use of health care services.

This pressure on health care cost increases is not likely to moderate. Experts expect a wave of new medicines and devices, including immunotherapies in oncology, breakthrough treatments for Alzheimer disease, and new gene and cell therapies. Each treatment offers great promise but is likely to further accelerate health care spending. Although there is a consensus that payers should support value, a unified framework for assessing value across a wide range of services does not exist.[12]

These cost increases and double-digit health insurance premium increases are likely to put pressures on the ACA. The ACA is still based on an exceedingly complicated set of rules and payments that are largely invisible to the public, but are essential in shoring up the stability of its more visible insurance markets. As costs continue to increase, provisions such as reinsurance and risk-corridors (whereby government limits insurers' risk), mandatory discounts for cancer drugs at certain hospitals and clinics (the 340B program), medical loss ratio regulation (regulating the proportion of premiums spent on reimbursing health care organizations and clinicians, and on quality improvement), and others will need to be adjusted or expanded. The rising frequency of "fixes" is an indication that the original ACA foundation may need more fundamental adjustments to keep these markets running efficiently, and an acknowledgment that the challenge of delivering "affordable" health care while covering every new innovation is likely impossible.

An example is President Obama's proposal to negotiate drug prices. This idea is shared by many politicians regardless of their party affiliation, but is difficult to accomplish. For instance, Medicaid is allowed to negotiate percentage discounts, but this encourages drug companies to increase the product price for all patients and offer rebates off the higher price.[13] For the United States to pay prices for branded drugs commensurate with the lower prices paid for those drugs in Europe will require a willingness to forego the use of high-priced ineffective drugs.

Are there better solutions to addressing the problem of high US health care costs? Prices are 1 component of cost. A study found prices for services such as a knee replacement operation that varied by a factor of 4 within the same city,[14] yet efforts to make these prices transparent has had little effect on consumer behavior.[15] It is unlikely that even doubling the Federal Trade Commission's budget will stem the tide of consolidation and mergers of health care entities, which lead to higher prices. Medicare is immune to this problem because of its reliance on centrally administered prices, suggesting that some combination of price regulation for highly monopolized health care organizations, and bundled payments that encourage new health care entrants to disrupt traditional hospital monopolies, may offer a way forward.[16-18] However, these approaches are not popular with hospitals and would require additional federal regulation. Whether future administrations (and Congresses) decide to dismantle the ACA or strengthen its foundations, they still must confront the unique challenge of getting health care spending under control—no insurance program is "affordable" as long as health care cost increases consistently exceed the growth of the gross domestic product.

A complementary approach to containing costs would be to strengthen a major innovation of the ACA, the national system of health insurance exchanges, or marketplaces, in which insurance companies (or even ACOs) offer a wide choice of well-defined health plans. These exchanges could offer a bright alternative to the current health insurance landscape because they provide the transparency of internet price-shopping for similar products. Under existing tax rules, however, exchanges are limited because only employer-provided insurance delivers substantial tax breaks, especially to their highly paid employees. With "premium support" for individuals who cannot afford health insurance, and tax credits providing a level playing field for all, these exchanges could be the foundation of the future of US health insurance, including Medicare.[19] For competition in the exchanges to lower premiums, one needs competitors, and the current wave of insurer mergers undermines the essential preconditions for success.

President Obama has every reason to be proud of a remarkable achievement. The nation is better off with the ACA, despite its shortcomings, than without. But health insurance, health care, and health, although often used interchangeably, are not the same. Even though the ACA has, to this point, not accomplished its goal of making health care more affordable, it is also far more moderate, innovative—and difficult to replace—than its critics claim.

ARTICLE INFORMATION

Author Affiliations: Department of Economics, Dartmouth College, Hanover, New Hampshire (Skinner); Dartmouth Institute of Health Policy and Clinical Practice, Geisel School of Medicine, Dartmouth College, Hanover, New Hampshire (Skinner); John F. Kennedy School of Government, Harvard University, Cambridge, Massachusetts (Chandra).

Corresponding Author: Jonathan Skinner, PhD, Department of Economics, Dartmouth College, 6106 Rockefeller Hall, Hanover, NH 03755 (jon.skinner@dartmouth.edu).

Published Online: July 11, 2016. doi:10.1001/jama.2016.10158.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Skinner reports being an investor in Dorsata and an unpaid member of the Altarum Institute's National Advisory Committee. Dr Chandra reports serving on the Panel of Health Advisors for the Congressional Budget Office; consulting for Precision Health Economics; and receiving personal fees from Biogen, Vertex, Pharmaceutical Care Management Association, and Novo Nordisk.

REFERENCES

1. Obama, B. United States health care reform: progress to date and next steps. *JAMA*. doi:10.1001/jama.2016.9797.

2. Finkelstein A, Taubman S, Wright B, et al; Oregon Health Study Group. The Oregon Health Insurance Experiment: evidence from the first year. *Q J Econ*. 2012;127(3):1057-1106.

3. Taubman SL, Allen HL, Wright BJ, Baicker K, Finkelstein AN; Oregon Health Study Group. Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. *Science*. 2014;343(6168):263-268.

4. Finkelstein A, Hendren N, Luttmer EFP. The value of Medicaid: interpreting results from the Oregon Health Insurance Experiment. http://www.nber.org/papers/w21308.pdf. Accessed June 27, 2016.

5. Colla CH, Wennberg DE, Meara E, et al. Spending differences associated with the Medicare physician group practice demonstration. *JAMA*. 2012;308(10):1015-1023.

6. Nyweide DJ, Lee W, Cuerdon TT, et al. Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. *JAMA*. 2015;313(21):2152-2161.

7. Chandra A, Holmes J, Skinner J. Is this time different? the slowdown in health care spending. *Brookings Pap Econ Act*. 2013;2013(Fall):261-302.

8. McWilliams JM, Hatfield LA, Chernew ME, Landon BE, Schwartz AL. Early performance of accountable care organizations in Medicare. *N Engl J Med*. 2016;374(24):2357-2366.

9. Colla CH, Lewis VA, Kao LS, O'Malley AJ, Chang CH, Fisher ES. Association between Medicare accountable care organization implementation and spending among clinically vulnerable beneficiaries. *JAMA Intern Med*. 2016. doi:10.1001/jamainternmed.2016.2827.

10. Altarum Institute Center for Sustainable Health Spending. Health economic indicators, insights from monthly national health spending data through April 2016:spending brief: June 10, 2016. http://altarum.org/sites/default/files/uploaded-related-files/CSHS-Spending-Brief_June_2016.pdf Accessed June 27, 2016.

11. Altarum Institute Center for Sustainable Health Spending. Health economic indicators, insights from monthly national price indices through April 2016:price brief: June 10, 2016. http://altarum.org/sites/default/files/uploaded-related-files/CSHS-Price-Brief_June_2016.pdf. Accessed June 27, 2016.

12. Chandra A, Shafrin J, Dhawan R. Utility of cancer value frameworks for patients, payers, and physicians. *JAMA*. 2016;315(19):2069-2070.

13. Duggan M, Scott Morton FM. The distortionary effects of government procurement: evidence from Medicaid prescription drug purchasing. *Q J Econ*. 2006;121(1):1-30.

14. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? hospital prices and health spending on the privately insured. http://www.nber.org/papers/w21815. Accessed June 27, 2016.

15. Brot-Goldberg ZC, Chandra A, Handel BR, Kolstad JT. What does a deductible do? the impact of cost-sharing on health care prices, quantities, and spending dynamics. http://www.nber.org/papers/w21632. Accessed June 27, 2016.

16. Skinner J, Fisher E, Weinstein J. The 125 percent solution: fixing variations in health care prices. http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/

17. Skinner JS, Weinstein JN, Fisher ES. Withholds to slow Medicare spending: a better deal than cuts. *JAMA*. 2012;307(1):43-44.

18. Kaplan RS, Porter ME. How to solve the cost crisis in health care. *Harv Bus Rev*. 2011;89(9):46-52, 54, 56-61 passim.

19. Elmendorf DW. Marshal J. Seidman lecture in health policy. http://www.brookings.edu/research/speeches/2015/11/02-seidman-lecture-harvard-elmendorf. Accessed June 27, 2016.