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Obamacare: what the Affordable Care Act means for patients and physicians

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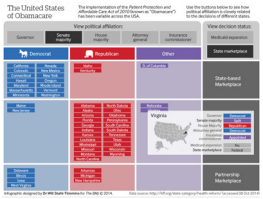
ABSTRACT

The Affordable Care Act's core achievement is to make all Americans insurable, by requiring insurers to accept all applicants at rates based on population averages regardless of health status. The act also increases coverage by allowing states to expand Medicaid (the social healthcare program for families and people with low income and resources) to cover everyone near the poverty line, and by subsidizing private insurance for people who are not poor but who do not have workplace coverage. The act allows most people to keep the same kind of insurance that they currently have, and it does not change how private insurance pays physicians and hospitals. Although the act falls short of achieving truly universal coverage, nine million uninsured people have received coverage so far. Market reforms have not hurt the insurance industry's profitability, prices for individual insurance have been lower than expected, and government costs so far have been less than initially projected. The act expands several ongoing pilot programs in Medicare that reform how doctors and hospitals are paid, but it does not directly change how private insurers pay healthcare providers. Nevertheless, it has set into motion market dynamics that are affecting medical practice, such as limiting insurance networks to fewer providers and requiring patients to pay for more treatment costs out of pocket. In response, many hospitals and physicians are forming closer and larger affiliations. Further time and study are needed to learn whether these evolutionary changes will achieve their goals without harming the doctor-patient relationship.



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Introduction

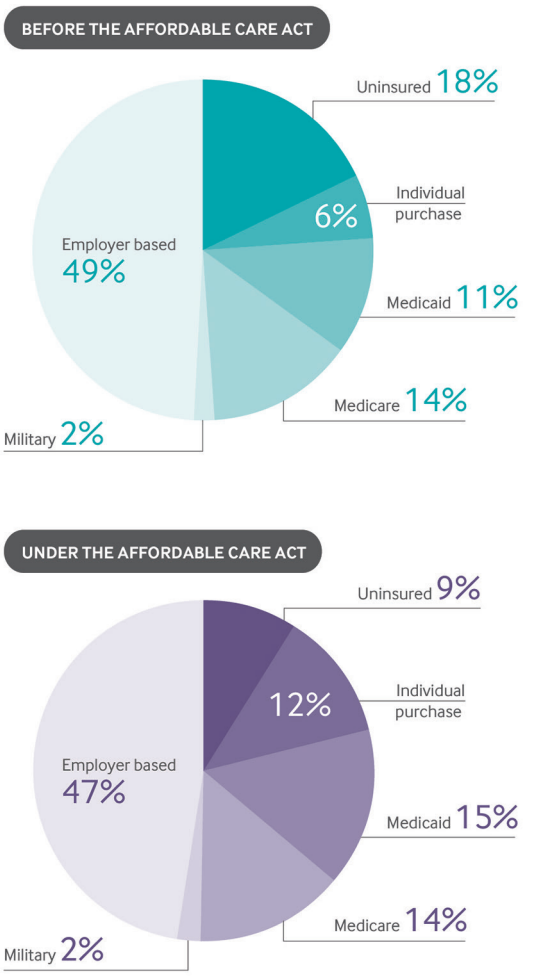
Not since the civil rights era has a federal social initiative in the United States been as contentious and polarizing as the ongoing debate over the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act"). Much of the intense opposition to this law has been motivated by political partisanship or by a belief that Congress used inappropriate legislative procedures to enact the law.[1-3] But much of the social and political debate focuses on health policy concerns. Will the act achieve its stated goals and avoid unintended consequences? Will it constitute a major intrusion into how medicine is practiced and reimbursed? And, if so, will that be to the detriment or benefit of patients and physicians?

Fierce and often emotional discussions of these questions often obscure a basic understanding of how the act functions. Confusion is understandable considering the law's complexity, so it is important to separate the law's core essentials from its more peripheral features. Also, many claims about the act are based on conjecture or implausible assumptions. Many patients will look to their physicians for information and guidance. Accordingly, this review begins with a description of how the act came about and what it aims to achieve. It then provides a summary of the act's major impacts on patients and physicians, based on reputable empirical studies.

SOURCES AND SELECTION CRITERIA

The Affordable Care Act is too new to have been studied extensively through scientific research. We were therefore unable to perform a formal scientific review. Instead, we reviewed the extensive public policy literature about the act in peer reviewed publications and published reports from government agencies and reputable (non-ideological) "think tanks," such as RAND, McKinsey, and the Urban Institute. We consulted all such major sources of public policy literature about the act published since 2010, which we identified through several search techniques. This included our own routine tracking of the literature and a "snowball" technique in which citations in key sources and to key sources are followed until saturation is reached, meaning that no substantially new information or perspectives are encountered. Much of this public policy literature is evidence based, in that it uses various techniques of descriptive data analysis to document or project the act's impacts, but summarizing these sources involved an element of subjectivity.

US insurance coverage before the Affordable Care Act and under the act. These are the authors' approximations. They are based on census data and Congressional Budget Office projections, and they assume that only about half of US states expand Medicaid



Health insurance before the Affordable Care Act

The healthcare system in the US struggles more than systems in other industrialized countries with two basic aspects of healthcare finance and delivery. It spends far more per person on healthcare than any other country, yet it is the only country in the developed world that fails to provide healthcare coverage for almost all of its residents. In 2010, 50 million people (16% of the population) had no public or private health insurance coverage, at the same time that the US spent close to $3tr (£1.8tr; €2.3tr) a year on medical care.[4] In proportion to its size, the US spends 50-100% more than peer nations, even though these other countries have healthcare coverage for almost all of their residents.[5]

One reason that the US spends this much is that financing for healthcare is more fragmented and privatized than in other developed countries. More than half the population has private insurance, mainly sponsored by employers for their workers and families (figure). Most private insurers are managed care (see Glossary) companies that encourage or require people to use doctors or hospitals in contracted networks. Outside the workforce, the federal Medicare program covers people who are disabled or over 65 years and retired. Medicaid, a joint state and federal program, covers some people who are poor, but, in most states, before the act's expansion, it covered only those who fitted into prescribed categories, such as single parents, children, and pregnant women.

People without public coverage or group insurance at work have had difficulty obtaining individual insurance, not only because of its expense, but also because private insurers screened people for health status (a process called medical underwriting) and either declined to cover people with potentially costly medical conditions, or charged them substantially more, or excluded coverage for their existing conditions. This is why only about 6% of the US population had individual (non-group) coverage. Before reform, insurance for small employers shared characteristics with both large group and individual insurance: small group insurance was more available and offered better coverage than in the individual market, but pre-existing conditions were excluded for one year, and insurers varied their small group rates according to age and other health risk factors.[6]

History of the Affordable Care Act

Republicans versus Democrats

A more socialized solution for healthcare reform favored by some left wing Democrats in the US would be to expand Medicare or create something like it that, along with Medicaid, covered everyone in a "single payer" system, like that in Canada. Despite Medicare's relative popularity with US patients and its success with constraining healthcare spending, staunch opposition to anything that smacks of socialized insurance keeps Congress from even considering "Medicare for all."

Right wing (Republican) proponents would prefer a less ambitious law that uses government subsidies mainly to help only those people who are not insurable, leaving the rest of the market to function as normal. This would also allow insurers to continue medical underwriting practices that screen people for health status and exclude pre-existing conditions. Moreover, because the 20% of people with the most expensive medical needs account for about 80% of spending,[7] uninsurable people are much more expensive than people realize and support for them is likely to be chronically underfunded.[8] Indeed, adequate funding of the top end of the medical expense distribution would end up "socializing" a major portion of medical spending.

Middle ground

The act was designed to avoid these extremes of right and left by aiming for a middle course that preserves a private insurance market for most people, but reforms the market so that it advances rather than undermines health policy goals.[2 9] Essentially, the act attempts to make the defective individual market (see Glossary) function much more like the successful large group market (see Glossary) for people above the poverty line. The act also expands Medicaid to cover everyone near or below the poverty line. This is the same pragmatic combination of approaches that conservative thought leaders (such as the Heritage Foundation) had previously advanced and that was successfully implemented in Massachusetts by its former governor Mitt Romney, a Republican.

How the act was passed

By using private market approaches endorsed by conservative thinkers to pursue liberal social goals, the Democrats who crafted the act hoped that it would be

Box 1 | Key features of the Affordable Care Act

- The act has been buffeted by ideological debate, and this has clouded the view of its merits, limitations, goals, and performance. Physicians need a clearer view so that they can help their patients have a better understanding of what the law means for them
- The act does not socialize medical care or payment. Instead, it charts a middle course between more socialist and conservative alternatives—one that expands on existing US structures and preserves a central place for the private market
- The act will not change the nature and type of insurance that most people have. Its main effects will be on people who previously were uninsured or who purchased individual insurance. Most of them are now eligible for Medicaid (in states that choose to expand) or for subsidized private insurance through the new state or federal exchanges
- The new insurance exchanges are highly competitive. Most offer a good range of options for individuals at prices that, even without subsidies, are similar to or lower than those for group coverage
- The act does not directly affect how private insurers pay physicians or hospitals. Its payment innovations are focused only on Medicare (see box 2).
- The act does not authorize private insurers or government agencies to intrude in medical decision making any more than they already do. Instead, it forbids the federal government from rationing care or limiting effective services purely on the basis of costs
- Private insurers are forming narrower provider networks for the individual insurance they sell through the subsidized exchanges. Patients may be worried or confused about whether their clinicians are included in these new networks
- Insurers are experimenting with different combinations of deductibles and copayments. This may increase patients' concern or confusion about how much particular courses of treatment will cost them
- As a continuation of previous trends, the act encourages, but does not require, greater clinical and financial integration among physicians and hospitals

acceptable to a broad swathe of the political and policy spectrum. Despite this reasonable expectation, Republicans uniformly opposed it, and the political consequences of this response are stark. Massachusetts' surprising election of a Republican to fill the seat vacated by Senator Kennedy's death in 2009 left Democrats one vote short of the supermajority needed to avoid blocking techniques by the opposition. Although the Senate previously had adopted a version of the Affordable Care Act, it differed from the House version. There was now no opportunity for a reconciliation process or careful proofreading. Instead, using legislative rules that allow purely budgetary and tax measures to advance with simple majority support, the Senate adopted a patchwork of amendments that made the Affordable Care Act acceptable to the House, and President Obama signed the law into effect in 2010.

The act's main features (box 1)

The act does much more than reform individual insurance and expand Medicaid, but most of these add-ons are peripheral to the law's main aim of insurance reform, so will not be considered here. Even limited to its core, however, the act is complex, but simpler solutions were not politically feasible or would not have achieved the core goals.

Universal insurability

Before discussing what the act covers it is helpful to clarify what it does not cover. It is not about regulating how private insurers pay providers. Also it does not achieve truly universal coverage, because it cuts the number of uninsured by only about a half (figure). Even after full implementation, 30 million people will still be uninsured. (About a quarter of the remaining uninsured will be eligible for Medicaid but not yet enrolled, another quarter will decline to purchase affordable private insurance, another quarter will still face unaffordable premiums, and the remaining quarter will not be US citizens or long term legal residents.)

If the act does not control costs or provide universal coverage, what does it do? The act's core and most important achievement is universal insurability. From 1 January 2014 insurers can no longer turn anyone away or refuse to cover pre-existing conditions (which is called "guaranteed issue"). In addition, insurers have to charge individuals and small groups rates that are based on population averages (which is called "community rating") rather than basing rates on individual characteristics. Guaranteed issue with community rating is an obvious boon for people who previously could not qualify, but universal insurability also benefits people who previously had good coverage. The knowledge that coverage will be available regardless of what happens enables people to change jobs, start new businesses, leave unhappy relationships, and make other major life choices that previously depended—at least to some extent—on whether insurability might be threatened in the process.[10]

Accomplishing the core goal of universal insurability requires more than simply regulating insurers. For this to work, people need subsidies so that they can afford insurance. And, to prevent people from simply waiting until they are sick to enroll, which would drive up insurance premiums even more, the act imposes an individual mandate (see Glossary) in the form of a tax penalty (ranging from 1% of taxable income in 2014 to 2.5% in 2016) if people fail to enroll in insurance that is affordable. (Affordable is defined for this purpose as single coverage costing ≤8% of household income). The act also requires larger employers (those with more than 50 full time equivalent workers) to pay a tax if they decline to offer minimum essential benefits (see Glossary). Administrative complications delayed this employer mandate (as it is known) for a year, until 2015.

Core insurance provisions

Most of the act's core insurance provisions flow from these few fundamentals—guaranteed issue, subsidies, and individual and employer mandates. Because insurance is expensive, sliding scale premium tax subsidies (see Glossary) are needed all the way up to four times the poverty level, which is almost $100 000 for a family of four—substantially more than the median household income. For people who cannot afford to contribute substantially to their cost of care, states can now expand Medicaid to cover everyone at or below 133% of poverty, rather than the uneven patchwork of Medicaid eligibility criteria that existed between various states.

To determine eligibility for subsidies and to facilitate choice among qualified plans, states are invited to create insurance exchanges, but if they do not, the federal government will operate one for them. Exchanges are web portals where people can shop among qualified insurers and determine their eligibility for subsidies. To qualify, insurers have to satisfy numerous criteria, to ensure

that people (and the government) receive decent value for their money and that insurers compete on fair terms. Requirements include offering a standard set of "essential health benefits" that cover a comprehensive range of services.

The act also requires insurers to package their patient cost sharing mechanisms (such as deductibles (see Glossary) and copayments (see Glossary)) in standard ways—labeled bronze, silver, gold, and platinum—according to whether insurance, on average, pays for 60%, 70%, 80%, or 90% of the required covered benefits.

The constitution and Medicaid

Immediately after the act became law, lawsuits that challenged its constitutionality were filed. Clearly, the federal government has constitutional authority to require Medicare for all,[11] but doing something short of that—expanding Medicaid and requiring people to buy private coverage—was attacked as exceeding congressional powers. In what is undoubtedly the health law case of the century, the Supreme Court ruled partially in both sides' favor.[12] It held that the Medicaid expansion is permissible but only if states can opt out of the expansion and still keep their current Medicaid funding. And, it ruled that the "individual mandate" is valid, but only if it is construed simply as a tax on a personal choice to decline coverage rather than as a penalty for violating a regulatory law that prohibits being uninsured.

This ruling allowed the act to survive, just barely (by a vote of 5-4 on the individual mandate), but in a weakened form. In particular, about half of US states so far have declined to expand Medicaid. In those states the subsidized exchanges can reach down to the poverty level but not below. This means that a high proportion of uninsured people on a low income in these states have no new options, even though people earning just a few dollars more qualify for free private coverage on the exchanges. Many states chose this upside down effect because they say they cannot afford their very small portion of the Medicaid expansion costs. Skeptics claim that politics, not state finances, are the main driver of states' decisions to refuse Medicaid expansion. They note that all of the states that refused are led by Republicans, and that they all also refused to establish insurance exchanges.[1 13]

Although states struggle to balance their budgets, state finances are not a compelling reason to refuse Medicaid expansion. The federal government will pay the full costs of expansion for the first two years and 90% of the costs by 2020. This would reduce states' existing financial burden of caring for the uninsured and would pay for additional care that saves citizens' lives and relieves suffering.[14 15] Moreover, Medicaid expansion would create jobs that generate more state and local tax revenue, sufficient to offset most or all of the states' small fraction of Medicaid costs.[16 17]

These refusals come at a high cost for states and their citizens. Opting out of Medicaid expansion does not relieve state citizens from paying the federal taxes that fund the act in other states. Not expanding puts many US hospitals in a particularly difficult position because those that serve a higher than average share of the uninsured will continue to do so, but the act cuts federal funds to support this uncompensated care across the board, having anticipated that all states would expand. It is not surprising, therefore, that several major medical centers across the country that have announced that they are cutting jobs are in states that have not expanded Medicaid.[18]

Misconceptions about the act

Socialized insurance

The act's most vociferous opponents say that it socializes medicine, meaning that the government has taken over the delivery of care. However, that is a misuse of the nomenclature. The distinction between socialized medicine and socialized insurance is that, with socialized insurance, the government pays for rather than delivers care. Considering the insurance element, congressional leaders originally proposed selling government insurance on the new exchanges and allowing older people to buy into Medicare before age 65 years, but both of these "public option" ideas were stripped from the law before it was passed to garner enough votes in the Senate.[2] Essentially what is left is a system for subsidizing and regulating the purchase of the same kind of private insurance that was already being sold in the market.

This subsidy and regulation scheme has many "social" elements, such as modified community rating, but they are not greatly more socialized than certain elements that prevailed in the market before the Affordable Care Act. The act allows individual and small group insurers to charge the oldest adults only three times more than the youngest adults. Threefold variation is less than the fivefold one that insurance actuaries would like, but a threefold variation is much more flexible than the market based form of community rating seen within large employer groups, where every worker in a group is charged exactly the same rate regardless of age.

Although the act mandates coverage of at least 60% of the actuarial value of a package of essential health benefits, the 60% level is much lower than what insurance typically covers in employer groups, and it is similar to what previously prevailed in the individual market. Similarly, the essential health benefits package is based mainly on what was the most popular insurance plan recently sold in each state's small group market.[19] Some other important aspects of the act push the private market towards more coverage and cross subsidization than occurs in the unregulated market, but overall the act mirrors rather than displaces many aspects of existing insurance market conditions. It is always possible that Congress might adopt further reforms that are more socialized than the Affordable Care Act, but nothing in the act's structure makes this likely.

Socialized medicine

It is also not accurate to say that the act socializes medical practice or payment. It does nothing that directly alters the fundamentals of how private insurance pays healthcare providers. One reason that the act was ultimately endorsed by the American Medical Association,

the American Hospital Association, and other major industry and trade groups is that it did not implement comprehensive payment reform or regulation for providers.[2 20] The act contains several innovations in payment methods, described below, but most of these are demonstration or pilot projects under Medicare, which already regulates payment rates, and these innovations build on ones that were already under way before the act came into law.

Similarly, despite concern that the government would control and ration care, the act does little to directly alter prevailing standards of practice or clinical autonomy. It creates new institutions that aim to improve quality and value (administered by the Patient Centered Outcomes Research Institute and the Center for Medicare and Medicaid Innovation), but they mostly just fund research or make proposals. Some potentially influential initiatives have not even been implemented, either because of a lack of funding (National Health Care Workforce Commission) or continued political and policy opposition (Independent Payment Advisory Board). Even if established, most of these study commissions and advisory boards differ little in their fundamentals from those that have been in place for decades, such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

Naturally, the story is more complex than this, but despite a sometimes alarming plethora of new organizations and acronyms, there is no new government authority that requires physicians to change how they practice or tells private insurers how to pay for care. Just the opposite, to assure that the act's initiatives do not compromise patient care or interfere with clinical judgment, the law contains a series of restrictive provisos that preclude "any recommendation to ration health care" (Independent Payment Advisory Board), any use of "dollars per quality adjusted life year" (Patient Centered Outcomes Research Institute), or any denial of benefits based on "age, disability, or expected length of life" (essential health benefits).[21]

Budget buster

Another misconception is that the act puts the federal government deeper into debt. Certainly, the act is not inexpensive; it is expected to cost about $1tr of federal spending over the first decade, even though it was not fully in effect for several of those years. Nevertheless, the law is designed to cover the federal government's costs through various tax increases and spending cuts (mainly to Medicare), so it is not expected to increase federal debt for the foreseeable future according to the Congressional Budget Office (CBO),[22 23] whose expertise and neutrality is not seriously questioned. Naturally, such projections often prove to be inaccurate and other government programs such as Medicare have ended up costing much more than initially forecast. However, this is not the experience so far. Because initial insurance rates were lower than expected, and about half the states have not expanded Medicaid, the CBO now projects that costs to the federal government will be about $30bn less per year than originally forecast.[24 25]

Government mandated insurance

Finally, there is merit to both sides of the debate about whether the act forces people to give up their previous insurance. The act will have little or no effect on most people who are already insured (figure). Eligibility for Medicare remains the same and expands for Medicaid. Large employers are not expected to, and so far are not planning to, drop coverage (although this remains speculative because of a two year reprieve for the employer mandate).[26-28] However, because small employers are not subject to an employer mandate, a fair number of them (but fewer than half) are expected to drop coverage, especially if many of their employees are eligible for substantial subsidies on the exchange.[28 29]

The act mandates that insurance sold to individuals and small groups (initially, groups of fewer than 50, but increasing to 100 in 2017) cover a comprehensive set of essential health benefits. Also, it caps out of pocket payments at $6350 for individuals and $12 700 for families. For those who want to avoid these mandates and keep the coverage they have, the law clearly permits continued renewal of plans that existed at the time of enactment, for as long as the insurer and the policyholder both wish to maintain coverage. This explicit statutory protection is the basis for President Obama's controversial pledge that, "if you like your insurance plan, you can keep it." This was true when the law first passed, but to remain true people had to have the same coverage that they had in 2010 and insurers had to avoid making any substantial changes to their plans. People and insurers change coverage frequently. Therefore, by the time the law's main provisions took effect in 2014, millions of people were no longer eligible to keep their coverage.[30] Moreover, many insurers decided to cancel their existing plans because it did not make business sense to keep plans that could not be sold to new subscribers. In addition, some states decided to require these cancellations. The ensuing uproar led the Obama administration to allow insurers to keep in place coverage that they had planned or begun to cancel. However, for many insurers this continuation was not feasible or was not allowed by state regulators.

Even for cancellation deadlines that were extended, sooner or later people will have to conform to the act's benefit minimums for individuals and small groups. Whether or not these minimum benefits are good policy is, of course, subject to debate. For instance, should coverage for maternity care be required even if many policyholders simply cannot have children? And, should insurance cover "habilitative services" that go beyond merely rehabilitating patients, to include various therapies that help people cope with chronic disabilities? Although coverage of these services is more comprehensive than what prevailed previously in the individual market, this coverage is similar to the most popular plans that had been for sale in the small group market and a bit less generous than what prevails for large employer groups.[19]

Impact on patients and consumers

For reasons just explained, the Affordable Care Act has little effect on the insurance coverage of roughly three quarters of the population (figure). The law's main effect

is that the number of people who are uninsured will be roughly halved by moving them to Medicaid (those below the poverty line) or subsidized private insurance sold through the new government exchange. Everyone with Medicare, and most people with Medicaid or employment based insurance, will continue to receive the same kind of coverage, from the same source, at price increases that are in line with medical cost inflation. Medicare recipients will be covered for more preventive care and will see coverage for prescription drugs expand. People with large group insurance (including self funded insurers) will also have better coverage for preventive services and will no longer be subject to lifetime or annual limits on total claims. These and other requirements undoubtedly add to the cost of insurance, but many of them have only a minor or negligible impact, in part because most private insurance already complied with the bulk of the act's requirements.

The act's primary impact is on the 18% of people who are uninsured, the 6% who have individual coverage, and the small proportion (so far) of people whose employers are dropping group coverage. These roughly 80 million people will need to decide between the following options:

- Remain as they are and pay a tax penalty (1% of income in 2014, increasing to 2.5% in 2016), unless they qualify for an exemption
- Enroll in Medicaid or with an employer plan, if eligible
- Purchase subsidized private insurance on the exchange (if their income is between 133% and 400% of the poverty line)
- Purchase full price insurance on their own.

Undocumented immigrants are not eligible for Medicaid or the exchanges.[31 32] Also, in states that do not expand Medicaid, people below the poverty level have no new options because exchange subsidies are available only above the poverty line.[14]

During the first open enrollment period (which ended in March 2014), about eight million people purchased individual insurance through the state and federal exchanges, exceeding expectations despite severe software problems.[25 33-35] About a quarter of these enrollees were previously uninsured.[33 34 36 37] Another six million uninsured people enrolled with Medicaid.[33 34 38 39] This enrollment surge could cause patients in some parts of the country to face a shortage of available physicians, especially primary care physicians,[40] but this has not yet happened,[41 42] and efforts (described below) are being made to increase primary care capacity.

Effect on insurance exchanges

Most of the insurance exchanges offer a good range of choice at prevailing prices.[43-47] Fears that the new law would drive insurers from the market in droves have not materialized. To the contrary, in each market segment (individual, small group, and large group), roughly 500 insurers throughout the country had at least 1000 members in 2012.[48] Moreover, insurers' stock prices have risen substantially more than the rest of the stock market,[49] and new insurers are entering the individual market in many states, in response to the opportunity for increased enrollment through the exchanges.[46]

Effect on community and average rates

Similarly overstated are charges that the act has caused massive "rate shock." It is true that community rating will increase rates for younger people by 30-40%, but it will also significantly lower rates for older people.[50] Early indicators of the market-wide effect on insurance rates are encouraging. Average rates for 2014 in the individual market (which includes the new exchanges) are almost 20% lower than the CBO initially projected, and in line with, or lower than, prevailing rates for group insurance.[24 44 51 52]

It is true that these rates exceed what many people previously paid in the individual market. But insurance under the act has better coverage (sometimes better than people want).[53] Also, insurance now covers all pre-existing conditions and allows people to undergo periods of non-coverage without worrying about their ability to requalify for coverage. Moreover, this insurance cannot be cancelled or rescinded and its premiums do not increase as steeply with age, or at all when people get sick or injured. These benefits come at a cost, which insurers require people to pay, but which the act subsidizes for most people.

Premium subsidies

The act's premium subsidies vary substantially according to income and family composition. It is therefore not easy to summarise the impact of these subsidies. However, because subsidies are available to people who earn up to four times the poverty level, most people who purchase individual insurance will be eligible for some subsidy.[30 50 54 55] Among those who qualify, the subsidy averages about $5000 per family.[23] The full net impact of these various components of insurance pricing (average rate, age rating, exchange subsidies) is not yet known but there will be more winners than losers.[30 54] Still, if only a small minority of existing policyholders face increases substantially more than general medical cost trends, this will amount to a few million people who will be worse off than before.

Medical loss ratio

Another of the act's benefits for consumers is its regulation of insurers' medical loss ratio, which is the proportion of the premium spent on medical claims and quality improvement as opposed to overheads such as sales costs, administration, and profits. Requiring insurers to rebate overheads that exceed 20% in the individual and small group markets, or 15% in the large group market, has resulted so far in almost $2bn of consumer rebates.[56] In addition, insurers reduced their overhead expenses by a similar amount after enactment of the law, and apparently in response to it.[48]

Summary of the act's impact on patients and consumers

The act seems to have had no unwanted consequences for most patients and consumers. However, the act has had a negative effect on less than 5% of people—those who are younger, healthier, and wealthier and so had lower rates and are not eligible for substantial financial assistance. There is also legitimate concern that the initial favorable

Box 2 | Medicare payment innovations in the Affordable Care Act

Community Care Transitions Program
Tests models to decrease readmission after Medicare funded hospital admission by improving communication between hospitals and primary care physicians. Models being tested include specialized clinics, enhanced home care services, partnerships between hospitals and nursing homes, and a return to home visits by doctors

Value Based Purchasing Program
A pilot program that shifts financial risk from Medicare to the physicians and hospitals that provide care. Current pilots include bundling hospital and physician reimbursement into a single payment for an episode of care

Shared Savings Program
Retains current payment structure but rewards groups of providers, referred to as accountable care organizations (ACOs), that can deliver quality care at lower cost. ACO structures are invisible to patients. Patients are attributed to an ACO on the basis of their voluntary provider relationships, which leaves them free to see non-ACO providers. In 2014, 200 ACO pilots were ongoing in the US, and their optimal size and organization is still under study.

market performance may not persist. Insurers' initial pricing was based on actuarial assumptions about the unknown age and health status mix of enrollees under the new market rules. If the actual experience is substantially worse, rates for individual coverage could rise considerably, or participating insurers could decline.

Impact on physicians and hospitals

Provider capacity and patient access

The surge in enrollment is expected to place a strain on provider capacity, especially for primary care physicians.[40] The full extent of this has not yet been seen,[42] but various measures are under way to increase primary care capacity.[57 58] The act increases funding for community health centers, and it increases payment rates under Medicare and Medicaid for primary care physicians and for team based patient centered medical homes (see Glossary).[59] The act also focuses on making more use of physician extenders (see Glossary), such as nurse practitioners and telemedicine. More time and research are needed to know whether these measures will suffice and how best to organize and fund primary care. Without these improvements, the act's increased coverage may not achieve its full potential to increase access to care and produce a measurable improvement in population health.

Cost control

The Affordable Care Act, despite its name, is much more about the cost of insurance than the cost of healthcare. Nevertheless, key provisions of the act are designed to help "bend the cost curve" in ways that could change how physicians work together across specialties and with hospitals. Almost all of these cost control initiatives focus on Medicare (box 2).[60-62] They include the Community Care Transitions Program, the Value Based Purchasing Program, and the Shared Savings Program. The major goal of these Medicare provisions is to move toward healthcare services being paid for on the basis of value rather than volume. In particular, Medicare is expected to make greater use of bundled payments (see Glossary) for episodes of illness, which hold hospitals and physicians jointly responsible for cost and quality for an episode of care.[63]

Pilots completed to date have had variable success and the optimal arrangements have not been clearly defined.[64 65] The open structure of accountable care organizations, for example, makes it more difficult for them to coordinate and manage care.[66] Accordingly, these organizations have not yet shown substantial savings.[60 67]

The prospect of marked change in Medicare payments might make the relationship between hospitals and physicians more collaborative or contentious. Initially, at least, providers are becoming more closely aligned. Many physician groups are being bought by hospitals, converting physicians from small business owners to employees.[68] It is too early to know whether these payment and organizational changes will enhance or erode the patient-physician interaction. Physicians may be rewarded for spending more time with patients rather than simply ordering more tests. But there is also the potential that cost or institutional constraints will make patients more wary of physicians' motivations.

The act continues existing trajectories

Medicine has been beset for decades with changes like these. Considering the Affordable Care Act's size, importance, and complexity, the tendency is to attribute almost everything that happens in healthcare delivery, especially unwelcome changes, to the act.[69] But much of the current change was under way before the act and clearly would have continued anyway.[70] Adoption of electronic medical records, for example, received a major bolus of funding from the bipartisan American Recovery and Reinvestment Act of 2009, and most delivery system changes directly fostered by the Affordable Care Act are focused on Medicare and not on private insurance.[61 71] For private insurance, the act continues to leave payment of healthcare providers to unregulated market forces. Its most overt cost control measure is to tax employers, starting in 2018, that offer especially generous health insurance. The act has, however, put into motion market forces that are bringing about further change in the private sector, in the form of narrower networks (see below) and increased patient cost sharing.

Narrower networks

To offer the most competitively priced product on the new exchanges, many insurers have asked providers to charge substantially less than they usually charge commercial insurers by accepting reimbursement closer to Medicare levels. Providers that are unwilling are often dropped from the networks that insurers offer on the exchanges. Thus, many insurers have much narrower networks for their products sold through the exchanges than those that they sell simultaneously to groups outside the exchanges.[43 72 73]

Narrow networks will provide a market test of the economic theory that individuals are more willing than

GLOSSARY

Bundled payment: Combining hospital and physician reimbursement into a single payment for an episode of care

Copayment: The portion of a medical bill paid by the patient rather than by the insurer

Deductible: The amount of covered medical expenses that an insured patient must pay entirely out of pocket in a year before insurance begins to pay anything

Employer mandate: Taxing larger employers that do not offer group health insurance to full time workers

Essential health benefits: The standard set of benefits that individual and small-group insurance must cover. It is generally set to the level of benefits that previously prevailed in each state's small group market

Individual insurance: Insurance that is not group coverage—for example, insurance purchased outside the workplace

Individual mandate: The requirement that people pay a tax if they do not sign up for insurance coverage that is affordable, as defined by law

Insurance exchange: A virtual or electronic marketplace in which people can shop for insurance among companies whose products have been vetted

Large group insurance: Insurance purchased by larger employers—those with more than 50 or 100 workers (depending on the particular definition that applies)

Managed care: A type of insurance that sets constraints on which doctors or hospitals are covered in full, that negotiates price discounts with medical providers, and that reviews the medical necessity of covered treatments

Minimum essential benefits: The ill defined level of insurance coverage that must be purchased to satisfy the individual mandate

Patient centered: A care delivery structure that assigns responsibility to a medical homes primary care provider to track and coordinate a patient's care received from multiple sources

Patient cost sharing: The portion of treatment costs paid by patients, through deductibles and copayments

Physician extenders: Healthcare providers that are licensed to provide some of the services also provided by physicians—for example, nurse practitioners and physicians' assistants

Premium tax subsidies: Financial support provided to people above the poverty line to purchase private insurance

employers to sacrifice breadth of choice among providers for lower premiums. Employers are less willing to do this when they choose a plan that covers a large number of workers, many of whom might find that their preferred physicians or hospitals are not in a narrow network. Individuals however may be willing to shop among different plans on the basis of which one has their preferred providers or they might be more willing to change physicians to save their own money.

If narrow networks persist, they might also expand beyond the government exchanges to offer lower cost options for employer groups, possibly through private exchanges.[74 75] If so, providers may face increasingly tough choices about how great a discount they are willing to confer. More than just price discounting, narrow networks form the scaffolding to construct private sector accountable care organizations and other arrangements that use alternative payment methods, such as capitation and bundled payment for episodes of care. Again, outside of Medicare, these are not required by the act, but they could develop in response to the market structures and forces that the act engenders.

Increased patient cost sharing

Another important trend affecting physicians is an increase in patient cost sharing (see Glossary). All insurance sold to individuals and small groups must cover the same comprehensive set of essential health benefits that are commonly covered in the large group market. However, insurers can attach markedly different levels of patient cost sharing to these comprehensive benefits, through various combinations of deductibles and copayments (see Glossary).[76]

Patient cost sharing has increased substantially in recent years as employers seek to keep premiums in check.[77] The exchanges present individuals with the same trade-off between premiums and cost sharing. In response, most consumers prefer the intermediate level of cost sharing offered by the silver plan, which requires patients on average to pay for 30% of their treatment costs. This is similar to what prevailed recently among small groups but is more cost burden than is common among large groups. Next most popular are bronze plans, which average 40% patient cost sharing, similar to the cost sharing level that had been most common in the individual market.

Insurers are also experimenting with which combination of the cost sharing elements is most appealing for consumers—for example, whether patients prefer lower deductibles that apply to all sources of treatment or higher deductibles that do not apply to primary care.

As patients sort through these options, they will increasingly turn to their physicians for better information about the actual costs of care and the availability of less costly options. Physicians are not accustomed to discussing treatment costs with patients, except perhaps to pick between generic and branded drugs.[78 79] We may be at the beginning of a shift in the doctor-patient relationship that requires a much more cost conscious style of patient communication and medical decision making.

Future prospects

The act's major provisions took effect only on 1 January 2014. Therefore, it is far too early to judge whether it is a shining success or utter failure. Most likely, it will be something in between, but it remains to be seen whether its advantages exceed its shortfalls and which aspects perform better or worse. Naturally, views will differ on how its performance should be measured. However, on the basis of the act's content and structure, it should not be expected to solve the major faults of US healthcare. Instead, it can be claimed to be successful if it substantially reduces the number of people who lack insurance without accelerating the increase in medical costs. The ultimate goals of universal coverage, effective cost containment, and optimal quality will have to await additional reforms.

FUTURE RESEARCH QUESTIONS

Does the Affordable Care Act's expansion of insurance coverage lead to measurable improvements in access to healthcare and in health status?

Is there sufficient healthcare delivery capacity to meet the needs of those who are newly insured in a cost effective manner?

Will the initial success of the new insurance marketplace exchanges be sustained or improved?

How will the new insurance market dynamics, especially the emergence of narrower provider networks, affect the development of accountable care organizations?

Will tentative new Medicare payment methods become firmly established and will they spread to the private insurance market? If so, how will they affect service delivery and quality?

Conclusion

Despite ideological opposition, the Affordable Care Act is not a radical transformation of health insurance or medical practice. Most Americans keep the same kind of insurance that they had before the act was passed. About half of US states have expanded Medicaid to cover all citizens near to the poverty line. People above the poverty line without job based insurance may now turn to new health insurance exchanges to buy normal private insurance, regardless of their health condition. Government subsidies make this private insurance affordable for most people, and people who decline to purchase insurance that the government deems affordable must pay a moderate penalty. Although these insurance reforms still fall short of achieving truly universal coverage, they do achieve universal "insurability," meaning that no one must worry about becoming uninsurable.

The act also contains various provisions that have some effect on medical practice, but nothing that fundamentally changes the government's relations with hospitals and physicians. Almost all of the act's payment reforms are localized to Medicare, which already regulates payment rates, and most of these innovations are being done only on a pilot basis.

The act does not directly change how private insurers pay hospitals and physicians. Nevertheless, it has set into motion market dynamics, such as narrower networks and increased patient cost sharing, which are affecting medical practice. In response, many hospitals and physicians are forming closer and larger affiliations. Further time and study are needed to learn whether these evolutionary changes will achieve their goals without harming treatment relationships.

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