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EDITORIAL

The Affordable Care Act: Objectives and Likely Results in an Imperfect World

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The Patient Protection and Affordable Care Act (ACA) has 3 main objectives: (1) to reform the private insurance market—especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level, and (3) to change the way that medical decisions are made. All 3 objectives rely primarily on private choices rather than government regulation and are rooted in expectations of rational decision making shaped by incentives but unfettered by other constraints. The implicit assumption is that individuals and groups will act within these reforms to produce a valued good (access to medical care) at an appropriate price (what it would cost an efficient provider) financed by fair risk sharing (spreading the cost of necessary services across a large pool). The result will be affordable care.

Although the ACA may go far toward this goal, the assumptions of efficient and fair mechanisms of

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interchange do not represent reality in many respects. There are many impediments to the underlying choices of all players. As a result, it will be necessary to correct for market failure if this essentially private approach to public policy is to succeed.

REFORM OF THE PRIVATE INSURANCE MARKET

Fundamental to the first objective are changes in the rules coupled with the individual mandate. Insurance companies must offer comparable policies at the same rates to all with relatively little variation allowed, not exclude preexisting conditions or cancel policies, and limit their rate increases—in other words, they must accept much more risk. To make this work, they must enroll a representative cross-section of the population to realize the average risk assumed under the new rules. The only way to achieve this is to require everyone to participate. But mandating purchase of insurance when one can't afford it is nonsensical—thus the necessity for the major subsidies included in the ACA.

For some reason, few have grasped how large this premium support is. For a family of 4 at the lower end of the income eligibility (150% of FPL, or about $35,000 per year), the subsidy would approach $13,000, offsetting an estimated annual premium of more than $14,000, leaving a net cost of around $100 per month.[1] This amount is deemed affordable. The subsidies are still more than 50% for a middle-income family purchasing their own coverage on the exchanges. With this much new purchasing power available to previously uninsured individuals, competition among insurers should be robust on the electronic exchanges. The key is that this competition is supposed to translate into both lower premiums and pressure on providers to do a better and more efficient job. If market failure keeps competition from achieving these outcomes, these imperatives will be blunted.

EXPANDING MEDICAID

As companion articles in this issue indicate, the Medicaid population has similar health needs whether now covered or in the planned expansion,[2] and coverage and treatment options are very important.[3] The expansion of Medicaid to the previously uninsured working poor is key. The Supreme Court thought otherwise, however, and made it optional. The issues in some states blocking the expansion concern the continuation of federal funding, how well Medicaid actually works, and its impact on mobility into the workforce. Interestingly, in general, big business is a strong backer of expansion, because they know they otherwise pay more to cross-subsidize uncompensated care. In fact, typically private payment is approximately 147% of average cost.[4] With more of the uninsured covered by exchanges and Medicaid, employers know they can obtain lower premiums, thus helping reduce benefit cost and allowing job expansion.

Yet the fear remains that the low-wage workers, who would be covered by expanded Medicaid, may be trapped in an inferior program. Actually Medicaid coverage is very good, although provider payments are not. The real problem is that available low-income jobs typically have no benefits. So to create a glide path from Medicaid to exchange coverage, the mandate and subsidies for individual and small business coverage are important. To make it even more seamless, some states (Arkansas and Ohio) are considering the use of Medicaid money to allow the purchase of the same exchange policies that would be available to these beneficiaries when their income makes them ineligible for continued Medicaid but qualified for exchange policies. The problem with this approach is that private policies will cost much more than Medicaid.

CHANGING MEDICAL DECISIONS

The third major ACA thrust of interest to family practice includes comparative effectiveness research (CER), alternative organizational arrangements (accountable care organizations, medical homes, etc), and compensation for new systems of delivery (telemedicine, group appointments, nurse-driven clinics, etc). A key assumption is that new information on better treatment alternatives (CER) will inform practice and stimulate value-based benefit design. In addition, the success of new organizational forms will depend on careful decisions by the primary care physician regarding where and how treatment occurs—especially for populations now badly managed. Both of these initiatives should move family practice into a central role. Finally, it is uncertain what the impact will be of alternative delivery methods developed in the Center for Medicare and Medicaid Innovation after the Office of the Actuary certifies them as effective and they are folded into the payment structure. Because they will result in payment changes, they certainly will affect primary care.

FAILURES IN THE HEALTH CARE MARKET

Yet the ACA may be doomed to far less impact than planned—especially regarding cost and value. There are serious problems in the way the US health system is organized and paid, in the information and choices available, and in the ability of participants to respond to the pressures and incentives provided in reform.

These problems will restrict the ACA's impact. Some market failures are well recognized, whereas most are known only by inside players in the current system.

The first problem occurs when decisions are delegated to someone who is supposed to act strictly in our interest as an agent, but doesn't. For instance, health insurance brokers who help small business select health plans receive a normal fee from their clients but also are paid by insurers for the volume they produce regardless of whether the contract is best for the firms who engaged them. These arrangements often mean the broker gets more of the premium than the primary care physician—without the knowledge of the small business! In a similar way, pharmaceutical firms pay rebates to insurers based on volume, which have an impact on what competing drugs are favored in the formulary. Closer to home, medical director compensation often goes to the largest admitter (for instance, in dialysis units), potentially affecting where specialty care is directed. Such incentives affect patient care decisions, resulting in higher costs and potentially less-than-optimal care. These agency costs are a serious impediment to the effectiveness of the ACA.

A second class of problems limits potential competitors. For instance, pharmaceutical patents are an accepted public policy. During the life of the patent, no competitors are allowed, although courts have decided that payment to delay entry by generic competitors is not acceptable.[5] In another area, the limited supply of physicians, both primary care and hospital based, restricts competition and allows distortion of the system. Shortage allows those in least supply, such as anesthesiologists, to bargain with hospitals and extract extra compensation in addition to their normal fees.[6] Beyond the insufficient numbers of primary care physicians that potentially limit access under the ACA, shortages in other specialties make it difficult to reorganize processes, negotiate alternative compensation, and introduce more efficient technology and other changes in practice that otherwise might flow from the incentives embedded in reform. Together these market barriers are a serious problem.

A third related group of limitations occurs when one party in a transaction has differential information that allows them to dominate or exploit decisions. Physicians clearly benefit from this almost by definition in dealing with patients. But it also occurs in direct-to-consumer advertising of prescription pharmaceuticals that creates demand sometimes unwarranted by clinical condition. Most advertising and promotion at all levels of the system are directed at this imbalance—sometimes correcting it through education, but often exploiting it to increase sales. In all these cases of asymmetric information, it is very difficult to have the meaningful market relationship between buyer and seller that is implicit in the market mechanisms underlying the ACA.

Finally, the plethora of perverse payment incentives is the most obvious problem in having informed free choice leading to the optimal outcomes desired. These incentives start with fee-for-service payment for individual services but continue with biases in the updates of the Medicaid fee schedule toward specialty services and away from primary care.[7] Some of these biases are well understood, whereas others are hidden in technical coding and payment processes. The latter are particularly hard to change. To the extent that these financial incentives restrict the impact of competition in the insurance market, payment problems may be the biggest threat to the impact of reform.

WHAT DOES IT MEAN FOR THE FUTURE AND WHAT CAN BE DONE?

There is no question that the ACA has changed the health system in the United States and will continue to have a profound impact in the years to come. It is less clear that we will realize the promise of higher value care efficiently provided in the best location at a fair competitive price. The insurance market—the primary target of health reform—definitely will be more competitive, open, and fair in access and cost.

The impediments in the provider and supplier sectors, however, will keep more intensive insurance competition from having the impact that it might on the structure of the system and the delivery of care. Demand may not flow to the best places if financial incentives continue to direct care to captive providers within a closed system and contracted partners, as it is likely to do in the absence of serious antitrust enforcement or limitations on contracting practices. Market forces exploiting information asymmetry may continue to drive drug and specialty care utilization beyond what new comparative effectiveness information and reorganized accountable care organizations might suggest would be more appropriate. The ability of hospitals, specialty physicians, and even primary care groups to negotiate collectively and threaten to withhold services can continue be used as a lever to extract higher payment in spite of pressure from the ACA.

As a worst case, the ACA will correct unacceptable failure in the insurance market practices, thereby increasing demand but leave the structural characteristics of the delivery system untouched. With the same cost drivers intact, the health sector might continue to eat larger portions of the gross domestic product until arbitrary payment cuts are invoked, as is included in the backup regulatory mechanisms of the ACA. Right

now health care inflation seems to have moderated to the point that this is less likely. But the threat remains, and the cause would be the market failures untouched by the ACA.

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