

# The Affordable Care Act: The Value of Systemic Disruption

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It is important to recognize the political and policy accomplishments of the Patient Protection and Affordable Care Act (ACA), anticipate its limitations, and use the levers it provides strategically to address the problems it does not resolve.

Passage of the ACA broke the political logjam that long stymied national progress toward equitable, quality, universal, affordable health care. It extends coverage for the uninsured who are disproportionately low income and people of color, curbs health insurance abuses, and initiates improvements in the quality of care. However, challenges to affordability and cost control persist.

Public health advocates should mobilize for coverage for abortion care and for immigrants, encourage public-sector involvement in negotiating health care prices, and counter disinformation by opponents on the right. (*Am J Public Health*. Published online ahead of print February 14, 2013; e1–e4. doi:10.2105/AJPH.2012.301180)

**IT IS IMPORTANT TO RECOGNIZE** the political and policy accomplishments of the Patient Protection and Affordable Care Act (ACA),<sup>1</sup> anticipate its limitations, and use the levers it provides strategically to address the problems it does not resolve. Passage of the ACA was a historic political achievement, breaking the logjam that long stymied national progress toward equitable, quality, universal, affordable health care in the United States. It has survived considerable challenges: a fractious legislative road to adoption in 2009 and 2010, more than 30 votes for repeal in Congress in 2011 and 2012, a Supreme Court case, and the national election of 2012. However, the benefits as well as the limits of this complicated law are poorly understood by the public,<sup>2</sup> and opposition will likely persist. In part, this is because major provisions of the law have not yet been fully implemented, in particular the expansions of coverage through health insurance exchanges and Medicaid, although implementation will create other problems. In addition, the ideological and structural barriers to a more functional health care system have been weakened but not eliminated.

## POLICY ACHIEVEMENTS OF THE AFFORDABLE CARE ACT

Health care absorbs an escalating proportion of government and private-sector spending, without commensurate benefits in health status and outcomes of care. Lack of coverage for health care is too often a crushing financial burden,<sup>3,4</sup>

as well as an avoidable cause of mortality,<sup>5,6</sup> among the increasing number of the uninsured. Access to medical care helps to shape the economic and social status of individuals and communities, and financial barriers to health care perpetuate inequalities rooted in income, race, and ethnicity.<sup>7,8</sup>

Although most Americans get health insurance coverage from their employers, until now there has been no requirement that employers provide it or that insurance companies accept anyone for coverage. Prior to adoption of the ACA, individuals who were not part of a large group found it difficult or impossible to find insurance. People with health conditions could be turned away for no other reason than the paradoxical one that they needed the service, and they also could be charged more if they succeeded in obtaining coverage.

The ACA establishes universal coverage for health care as a national goal and delineates the responsibility of individuals, employers, and the government to contribute to its cost (Table 1). It has already extended health care coverage for millions through provisions such as continuing coverage for dependents on a parent's health plan through age 26 years. Beginning in 2014, it will direct federal funds to states that choose to participate to significantly expand coverage for very-low-income residents through the state–federal Medicaid program. Other uninsured individuals and some employers will be required to purchase private health insurance through publicly administered health insurance exchanges. However, the law excludes

undocumented immigrants from these new coverage options and offers reduced benefits for those legally present.

The law protects consumers from the most egregious insurance company abuses. Insurance plans that operate through the health insurance exchanges must accept all applicants and cannot set premiums according to health status. The ACA eliminates copays and deductibles for preventive services such as contraception, mammograms, colonoscopies, immunizations, prenatal and new baby care, and annual physicals for Medicare beneficiaries, and expands the number of primary care clinicians and the supply of services. However, it places some restrictions on coverage for abortions.

The law limits the percentage of revenues insurance companies can spend on administration, as opposed to medical benefits, and gives the Secretary of the Health and Human Services Department some leeway to reject excessive premium increases. States can strengthen premium rate regulation. The new Independent Payment Advisory Board proposes to apply the beginning of deliberative payment rates in the Medicare system. However, the continuing role of the private for-profit insurance industry and corporate imperatives such as consolidation among hospital chains are likely to frustrate efforts to control health care expenditures. The ACA provides significant leeway to states to experiment with alternative methods of financing and organizing health care, effective in 2017 (Table 2).

**TABLE 1—The Affordable Care Act’s Expansions of Coverage in 2014 Through Medicaid and Health Insurance Exchanges**

Program Characteristic	Medicaid	Health Insurance Exchange
Provisions	Covers comprehensive benefits for very-low-income people State/federal funding for benefits, administered by states	Offers a menu of standardized private health insurance plans with stated benefits State or federal government administers an exchange in each state Premiums paid by enrollees Extensive federal subsidies and tax credits available to individuals and small businesses.
Beneficiaries	Everyone with income ≤ 138% of federal poverty level (\$14 856 for an individual in 2012) <sup>a</sup>	Any individual > 200% of poverty not covered in a group health plan as an employee or dependent Individuals whose job offers health insurance, but premium exceeds 9.5% of income Businesses with ≤ 50 employees Employers with > 50 employees pay a penalty for employees who enroll through an exchange because employer’s plan is too expensive
Potential new enrollees	17 million	25 million
New elements	States may no longer exclude people on the basis of incomes lower than 138% of poverty; count any asset, including a car, as part of income; or require other categories of eligibility, typically having children or a severe health condition	Participating plans must accept any applicant Every individual without another source of coverage must purchase it Members of Congress and their staff must use the exchanges for coverage
State and federal roles	Federal government pays states for coverage of newly eligible, at 100% for 2014–2016, 90% by 2022  Federal government pays for higher reimbursement rates for primary care providers States can choose to accept or decline expanded coverage and federal funds	States may establish exchanges Federal government will operate in states that decline
Limits	Some states intend not to participate Perpetuates separate system of coverage for low-income people	Limited levers to ensure affordable prices All participating insurance plans are private Larger employers cannot participate until 2017 Undocumented immigrants cannot enroll

<sup>a</sup>Level set at 133%, but an offset brings it in practice to 138%.

**LIMITS OF THE LAW**

Most analysts agree that the law will have limited effectiveness at controlling health care expenditures, for 2 related reasons. The ACA will leave a substantial number of residents uninsured. An estimated 26 million people will remain uninsured in 2016,<sup>9</sup> among them immigrants and people who are exempt from the mandate because they do not

have access to affordable coverage or they choose to pay a penalty rather than purchase health insurance. This number may be higher if some states do not implement the Medicaid expansion. This leaves a rotating pool of uninsured individuals at continued risk for illness and financial hardship. In addition, providers cannot plan how to charge or pay for the uninsured, who will ultimately require care. Systems to align

payment and performance, such as reducing payments to hospitals that readmit patients soon after discharge, are ineffective if no clear source of reimbursement is in place.

A second obstacle is that the most effective methods for controlling health care costs involve authorizing the government to negotiate prices with health care providers, including hospitals and pharmaceutical corporations,

as the only entity with the bargaining muscle and the mission to be effective and to streamline administrative complexity. Medicare at least partially fills this role for most US residents older than 65 years and for some people with disabilities, and the Department of Veterans Affairs sets or negotiates prices for the health care services it provides for veterans.

The ACA offers some avenues to wider-scale negotiations on cost, for example, through the administration of the exchanges, the expansion of Medicaid, and the option for state experimentation in 2017. But at least initially, the new exchanges can offer only private health insurance plans, with no option to buy into a new public-sector plan or Medicare; participation will be limited initially to individuals and small employers, precluding a bargaining alliance with and among large employers.

Two questions then arise: What factors have impeded more comprehensive reforms, namely, universal coverage, and effective cost controls? What can be done to overcome these obstacles in the future?

**ENTRENCHED INTERESTS**

It is both humane and cost-effective to ensure that whole populations receive comprehensive health care. It costs more to keep some people uninsured than it does to cover everyone.

Organized medicine, for-profit hospitals, and the pharmaceutical and insurance industries profit from the absence of universal coverage. The resulting instability allows them to create and administer complex systems for categorizing customers and to charge different customers

**TABLE 2—Implementation Timeline for the Affordable Care Act**

Year	Increase Coverage and Access to Health Care	Protect Consumers	Improve Quality and Lower Costs
2010	<ul style="list-style-type: none"> <li>Preexisting condition insurance plans offer coverage to uninsured</li> <li>Extend dependent coverage to young adults up to age 26 years</li> <li>Tax credit up to 35% for small businesses that offer insurance</li> <li>Expand primary care workforce via Public Health and Prevention Fund</li> </ul>	<ul style="list-style-type: none"> <li>No preexisting condition exclusions for children younger than 19 years</li> <li>Insurance companies cannot drop coverage midstream (no rescissions)</li> <li>Eliminate lifetime caps on coverage</li> <li>New independent appeals process, with grants to states for offices of health insurance consumer assistance</li> <li>HealthCare.gov and CuidadodeSalud.gov offer consumer information</li> </ul>	<ul style="list-style-type: none"> <li>Eliminate copays and deductibles for preventive services (commercial plans and Medicare)</li> <li>Crack down on health care fraud</li> <li>Close Medicare drug gap with \$250 rebate</li> <li>\$5 billion federal fund will subsidize high-cost medical claims of early retirees</li> </ul>
2011	<ul style="list-style-type: none"> <li>Increase number of primary care doctors, nurses, nurse practitioners, physician assistants through new investments</li> <li>Expand community health centers</li> </ul>	<ul style="list-style-type: none"> <li>Require medical loss ratio: insurance plans must pay 80%–85% of revenues for subscribers' health care, or pay rebates</li> </ul>	<ul style="list-style-type: none"> <li>Close Medicare drug gap with 50% discount on brand-name prescription drugs</li> <li>States can require insurance companies to submit justification for requested premium increases, adding transparency and strengthening state oversight of premiums</li> <li>Connect Medicare payments to quality outcomes</li> </ul>
2012	<ul style="list-style-type: none"> <li>Establish Medicare Independence at Home demonstration program for chronically ill Medicare patients.</li> <li>Increase Medicaid payments for primary care services.</li> </ul>	<ul style="list-style-type: none"> <li>Department of Health and Human Services must set regulations on requirements for health plan quality reporting</li> </ul>	<ul style="list-style-type: none"> <li>Establish Independent Payment Advisory Board for Medicare</li> </ul>
2013	<ul style="list-style-type: none"> <li>Increase funding for Children's Health Insurance Program</li> <li>Expand small business tax credit</li> </ul>	<ul style="list-style-type: none"> <li>Limit tax deductibility of compensation to health insurance company executives</li> </ul>	<ul style="list-style-type: none"> <li>Expand Medicare authority to bundle payments</li> </ul>
2014	<ul style="list-style-type: none"> <li>Insurance exchanges available for individuals and small businesses</li> <li>Allow Medicaid to cover everyone ≤ 133% of poverty</li> <li>Individual coverage mandate begins; insurance can be purchased through exchanges; subsidies available for persons ≤ 400% of poverty</li> </ul>	<ul style="list-style-type: none"> <li>Eliminate discrimination for preexisting condition or gender</li> <li>Eliminate annual caps on coverage</li> </ul>	<ul style="list-style-type: none"> <li>Changes in Medicare delivery system; implement cost containment policies</li> </ul>

different prices. In addition, employers and some labor unions have asserted their interests in keeping workers dependent on the workplace for health insurance.<sup>10</sup>

Identifying equally powerful constituencies capable of marshaling countervailing political momentum has always been complicated in the United States. Since the 1980s, transnational corporations have campaigned aggressively to defund government and undermine and discredit its functions, including its role as provider, protector, or regulator of health care and other social services.<sup>11</sup> Measures authorizing the public sector to

negotiate, set, or otherwise constrain the prices of medical services have withered in the face of opposition from the health care industry.

Ideological messages that present and defend corporate prerogatives as a matter of personal, individual choice underlie such perverse arguments as (1) people deserve only the health care they can pay for individually, and (2) government authority is equivalent to tyranny, whether used to compel individual contributions to pay for health care or to set health care prices. For years after the ACA was adopted, the media echoed charges by House of Representatives Speaker

John Boehner that the expansion of coverage through an individual mandate and other provisions infringes on Americans' "freedom" from "government bureaucrats."<sup>12</sup>

The House majority spent an unprecedented number of days in votes and hearings attacking reproductive health care and rights, including threats to defund Planned Parenthood. Speaker Boehner charged that a regulation requiring coverage for contraception on the same terms as other preventive health care benefits for women, such as screenings for HIV/AIDS and pregnancy-related diabetes, was a government intrusion on freedom.

**THE VALUE OF SYSTEMIC DISRUPTION**

Structural factors tend to rig the US political system against tectonic changes, regardless of the particular issue at hand. Decision-making power is divided among the three branches of the federal government, as well as state and local jurisdictions.<sup>13</sup> Disadvantaged populations lack avenues readily available to the wealthy to pursue power and change, reinforcing the tendency toward the status quo.<sup>14</sup> Even incremental steps to advance the public's interest, if they challenge financial or corporate interests, require extraordinary feats of political legerdemain.

In this context, 2009 presented a rare window of opportunity. President Barack Obama's leadership in 2009, and his extensive compromises with most of the industry, achieved an uneasy but ultimately effective alliance that propelled the legislation to Congress. Opposition challenges manifested through such groups as the Tea Party were countered by community coalitions and labor groups, many mobilized and reinvigorated by the 2008 election campaign. One critical example was the online Virtual March on Washington, which generated a record 1.2 million pro-reform messages to Congress on February 24, 2010, just before the president's televised summit with congressional Republicans.<sup>15</sup>

Nevertheless, passage in Congress required extraordinary procedural maneuvers by the House and Senate leadership.<sup>13,16</sup> Some conservative Democrats agreed to vote for the law primarily in the belief that failure to do so would result in their party losing its congressional majority, and thus its control of committees, in the 2010 elections, as occurred in 1994 when the majority-Democratic Congress failed to act on President Bill Clinton's health care reform proposal. Some of these members demanded concessions on coverage for abortion care and for immigrants, which likely hastened the loss of Democratic seats in the 2010 election. The ACA squeaked through the House with a vote of 219 to 212, and was signed into law on March 23, 2010.

Although the ACA leaves the United States saddled with the perverse incentives of the for-profit health insurance industry, it opens the door for or implements many of the elements of the progressive proposal for comprehensive reform that Senator Paul

Wellstone introduced in 1993, which he and I described:

[F]ree choice of providers, including consumer-oriented managed-care plans; streamlined and publicly accountable administration; universal coverage based on residency instead of employment; comprehensive benefits with an emphasis on primary and preventive care; quality controls based on outcomes data and designed with the involvement of providers and patients; equitable financing; and affordability.<sup>17(p1489)</sup>

The Wellstone–McDermott–Conyers bill prominently called for public financing and fixed federal health care budgets and would have virtually eliminated profits in health care, policies that are not part of the ACA. At some point, we will face a reckoning with the inevitably pernicious and inflationary influence of the for-profit private insurance system. The ACA, although imperfect, paves the way for these efforts and even establishes structures and timelines in which they can occur.

## A STRATEGY FOR FURTHER PROGRESS

Faced with attacks 2 years running on the ACA, reproductive rights, and immigrants' rights, and abetted by a savvy voter turnout operation, women, people of color, immigrants, and young people voted in substantial numbers in the 2012 election and rejected the attack campaigns of 2011 and 2012. It may now be possible to break the barriers to public debate presented by social divisions such as the stigmatization of abortion and the unequal treatment of immigrants.

Successfully implementing and improving the ACA will require consistent oversight by the public. Advocates need to think strategically about how to create

and pursue opportunities at the state and national levels to expand coverage, improve the quality of care, and mobilize support to implement these provisions, while developing strategies to secure the stronger government authority that will eventually be necessary to control health care prices and expenditures, counter the influence of the for-profit insurance industry, and ensure affordability. The demand for affordable health care, available to all, remains a matter of social and economic justice and human rights. ■

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