

## Health Policy Review


**Patient Protection and Affordable Care Act of 2010:  
Reforming the Health Care Reform for the New  
Decade**

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The Patient Protection and Affordable Care Act (the ACA, for short) became law with President Obama's signature on March 23, 2010. It represents the most significant transformation of the American health care system since Medicare and Medicaid. It is argued that it will fundamentally change nearly every aspect of health care, from insurance to the final delivery of care. The length and complexity of the legislation and divisive and heated debates have led to massive confusion about the impact of ACA. It also became one of the centerpieces of 2010 congressional campaigns.

Essentials of ACA include: 1) a mandate for individuals and businesses requiring as a matter of law that nearly every American have an approved level of health insurance or pay a penalty; 2) a system of federal subsidies to completely or partially pay for the now required health insurance for about 34 million Americans who are currently uninsured – subsidized through Medicaid and exchanges; 3) extensive new requirements on the health insurance industry; and 4) numerous regulations on the practice of medicine.

The act is divided into 10 titles. It contains provisions that went into effect starting on June 21, 2010, with the majority of provisions going into effect in 2014 and later.

The perceived major impact on practicing physicians in the ACA is related to growing regulatory authority with the Independent Payment Advisory Board (IPAB) and the Patient Centered Outcomes Research Institute (PCORI). In addition to these specifics is a growth of the regulatory regime in association with further discounts in physician reimbursement. With regards to cost controls and projections, many believe that the ACA does not fix the finances of our health care system – neither public nor private. It has been suggested that the Congressional Budget Office (CBO) and the administration have used creative accounting to arrive at an alleged deficit reduction; however, if everything is included appropriately and accounted for, we will be facing a significant increase in deficits rather than a reduction.

When posed as a global question, polls suggest that public opinion continues to be against the health insurance reform. The newly elected Republican congress is poised to pass a bill aimed at repealing health care reform. However, advocates of the repeal of health care reform have been criticized for not providing a meaningful alternative approach. Those criticisms make clear that it is not sufficient to provide vague arguments against the ACA without addressing core issues embedded in health care reform.

It is the opinion of the authors that while some parts of the ACA may be reformed, it is unlikely to be repealed. Indeed, the ACA already is growing roots. Consequently, it will be extremely difficult to repeal.

In this manuscript, we look at reducing the regulatory burden on the public and providers and elimination of IPAB and PCORI. The major solution lies in controlling the drug and durable medical supply costs with appropriate negotiating capacity for Medicare, and consequently for other insurers.

**Key words:** Affordable Care Act, health care costs, health care regulation, health care reform, Patient Centered Outcomes Research Institute, health exchanges, health care subsidies, health insurance premiums, uninsured, Medicare, cost control

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*“After a century of striving, after a year of debate, after a historic vote, health care reform is no longer an unmet promise. It is the law of the land.”*

President Barack Obama

**O**n March 23, 2010, President Obama signed into law the most sweeping health care system reform legislation since Medicare was enacted in 1965. The debate has been both heated and divisive. However, this was not limited to Republicans and Democrats; the public and health care providers were right in the center. In this protracted debate, honorable people have taken strong, principled stances on how best to bring about meaningful reform of this nation’s broken health care system and vigorously supporting or opposing it.

In our previous manuscript of 2009, we described Obama health care for all Americans and the practical implications (1). The manuscript presented multiple issues of health care spending at crisis levels and the great expectations of its reform (2-6). Since then, a substantial amount of new literature has emerged, basically polarized either in support or opposition of the Patient Protection and Affordable Care Act of 2010 (the ACA, for short) (7).

The supporters indicated that the passage of comprehensive health care reform legislation presents tremendous opportunities to improve the way that America’s health care system works. They believe that the reforms to expand coverage hold the potential to help millions of Americans. The opponents of health care reform claimed that ACA will transfer one-sixth of our economy into the hands of politicians and agency bureaucrats – leading us down the road to a single-payer “Medicare for All” system that, in their opinion, virtually guarantees a spectacular failure.

Phillip Bredesen, a popular 2-term Democratic governor of Tennessee, not only criticizes and opposes the reform, but provides a road map to fix reform and build a sustainable health care system (8). He argues that Congress and the Obama administration have added over 30 million people into an obsolete,

broken system and have done little to address the underlying problems: its unsustainable finances and threat to our nation’s future. Rather than providing real solutions, the reform simply added new layers of bureaucracy and complexity to this baroque system. He added that without dealing with tough problems — cost, sustainability, and quality — true reform will be elusive.

Health care reform became a major component of campaigning for the 112th Congress in 2010. The results of this 2010 midterm election were described as a “shellacking” by President Obama, and they represented a wake-up call for Democrats and Republicans alike. In large part due to widespread dissatisfaction, the country’s economic performance, and a lack of public confidence in the ACA, Republicans gained control of the House of Representatives and will have additional votes in the Senate (9). This return of greater congressional power to the Republicans creates a tougher political climate for the administration in implementing health care reform. It also poses a challenge to Republicans. While Democrats and Republicans agree that systematic reform of health care delivery and payment and implementation of the ACA are monumental tasks, Republicans are preparing to make substantial changes in the legislation, whereas the administration is poised to implement the legislation (10,11). The law includes numerous health-related provisions to take effect over a 4 to 8 year period, mandates for individuals and businesses, prohibition of denying coverage or refusing claims based on pre-existing conditions, expanding Medicaid eligibility, insurance regulations, health insurance exchanges, regulations for the practice of medicine, Medicare cuts, and support for medical research (7).

In short, the ACA is not only historic and transformational, but profoundly troubling for some and controversial for many.

## 1.0 INTRODUCTION TO THE AFFORDABLE CARE ACT

The ACA is the most consequential social legislation of our generation. Some have considered this to surpass the Social Security Act of 1935, the Medicare Legislation of 1965, and Medicare Modernization Act (MMA) of 2003 (12). Of all the major legislations, the ACA is noteworthy for not having any bipartisan support (Table 1) (13). The ACA is expected to directly affect every American citizen. Depending on one's point of view that might be positive or negative. But whatever it is, the fact remains that despite individual mandates, employer mandates, Medicare cuts, Medicaid expansion, health exchanges, and mounting regulations, a significant proportion of Americans will be left without insurance.

### 1.1 What is the Affordable Care Act?

Kleinke (14) described the ACA as:

- ◆ Health insurance market reform with no exclusions, no exceptions, and a community rating.
  - ◆ Individual mandate, buoyed by subsidies and enforced by penalties.
  - ◆ An employer mandate for all but the smallest workforces.
  - ◆ Health insurance exchanges.
- He described that health reform provides access to:
- ◆ Health insurance, regardless of medical history or employment status.
  - ◆ Federal subsidies for the poor.
  - ◆ Expanded access to Medicaid.

Health reform will be financed by:

- ◆ Direct tax penalties if citizens have no health plan through their job or have not purchased one on their own.
- ◆ Indirect penalties for individual plans with new taxes on high-end health plans.
- ◆ Indirect expenses for job-based plans with lower coverage levels and/or diverted wages, capped flexible spending accounts (FSAs) and health spending accounts (HSAs), and indirect expenses for all with increased costs for drugs and medical devices in order to cover new fees.

Laszewski (15) described that health care reform was not really a reform, but was a major entitlement expansion funded equally by new taxes and modest provider cuts. He described that Obama and the Democrats have scored a major victory by:

- ◆ Creating a new entitlement with establishment of a defined benefit approach to health care.
- ◆ By providing key constituencies with a great deal to lose and gain from the government.
- ◆ Expanding health care entitlement to an additional 32 million people and guarantee coverage to everyone.

However, he added that the ACA did it without solving the big underlying problem, i.e., controlling costs. Key elements of the bill include the individual mandate, expansion of Medicaid for the poorest, the employer mandate to offer coverage, regulations for insurance companies to cover everyone, and minimum standards for health plans (15).

Table 1. Votes on major social legislation.

Bill	Total Vote For:Against	Republicans		Democrats	
		Yea	Nay	Yea	Nay
<b>House of Representatives</b>					
Social Security Act of 1935	372:23	77	18	288	13
Social Security Amendments of 1965 (Medicare and Medicaid)	307:116	70	68	237	48
Personal Responsibility and Work Opportunity Reconciliation Act of 1996	328:101	225	2	100	98
Medicare Modernization Act of 2003	220:215	204	25	16	189
Affordable Care Act of 2010	220:207	0	175	220	32
<b>Senate</b>					
Social Security Act of 1935	77:6	15	5	60	1
Social Security Amendments of 1965 (Medicare and Medicaid)	70:24	13	17	57	7
Personal Responsibility and Work Opportunity Reconciliation Act of 1996	78:21	45	0	23	18
Medicare Modernization Act of 2003	55:44	42	9	11	35
Affordable Care Act of 2010	56:43	0	40	54	3

Adapted from: Aaron HJ. The midterm elections- high stakes for health policy. *New Engl J Med* 2010; 363:1685-1687 (13).

Tanner (16) in a CATO Institute publication described the ACA as follows:

- ◆ The new law is not universal coverage.
  - By 2019, roughly 21 million Americans will be uninsured, even though the law will increase the number of Americans with insurance coverage.
- ◆ The legislation will cost far more than \$2.7 trillion over 10 years of full implementation, and with an added \$352 billion to the national debt over the period, instead of the less than \$1 trillion as proposed.
- ◆ While most American workers and businesses will see little or no change in their skyrocketing insurance costs, millions of others including younger and healthier workers and those buying individual policies would actually see the premiums go up faster as a result of this legislation.
- ◆ The new law will increase taxes by more than \$669 billion between now and 2019, and the burden it places on business will significantly reduce economic growth.

Bredesen (8) described that the ACA:

- ◆ Creates a mandate for individuals and businesses, requiring as a matter of law that nearly every American have an approved level of health insurance or pay a penalty.
- ◆ It establishes a system of federal subsidies to completely or partially pay for now-required health insurance for about 34 million Americans who are currently uninsured.
  - These subsidies are made available through a combination of expanding the existing Medicaid program and creating new entities called exchanges.
- In addition, several million Americans who currently have health insurance are expected to convert to subsidized coverage through the exchanges.
- ◆ It places extensive new requirements on the health insurance industry.

Supporters of health care reform such as the Commonwealth Fund (17), claim that health care reform not only will cover more Americans, but also bend the cost curve. They suggest the reform on National Health Expenditures (NHE) (18) will have an impact on new coverage, savings, and public programs; insurance exchanges and the public options; health system modernization, and its impact on the Medicare and the federal budget; premiums for private coverage; and, finally, savings for the entire system and improvement in every aspect for all Americans.

## 1.2 Implementation

The act is divided into 10 titles. It contains provisions that went into effect starting on June 21, 2010, and a majority of provisions which will go into effect in 2014 and later (Table 2) (19,20).

As illustrated in Table 2, there are multiple regulations to be implemented. The health care law itself is 2,407 pages. Now it is expected that the regulations to implement the law could be 4 times the size of the law itself (20).

## 2.0 ESSENTIALS OF THE AFFORDABLE CARE ACT

Essentials of the ACA have been described in multiple publications, most of them partisan and opinion based. Bredesen's review (8) appeared to be less partisan as he is a Democrat. The majority of the description of the essentials of the ACA is derived from Bredesen's book.

### 2.1 Mandate

Bredesen (8) described the "mandate" is a legal requirement that nearly every American citizen and legal resident must have health insurance or pay a penalty. Mandated, minimum requirements are similar to conventional health insurance policies, with a notable additional emphasis on access to preventive care (8).

There are financial penalties in the form of a new tax on individuals who fail to buy health insurance and a penalty on employers above a certain size who don't cover their employees. The Internal Revenue Service (IRS) is the agency charged with enforcement. Those penalties on individuals, after a brief start-up period, are \$695 annually for each individual (limited to 3 times that amount for any family) or 2.5% of income, whichever is greater. An individual without the required insurance and with an income of \$20,000 pays a tax of \$695; at \$50,000 the tax is \$1,250; at \$100,000 it's \$2,500 (8).

There are a number of exceptions to the requirement to buy health insurance, including various forms of financial hardship, being without coverage for 3 months or less, being an American Indian, or being in prison (8).

### 2.2 Subsidies

The ACA establishes a system of subsidies for the purchase of health insurance that are based primarily on income and family size. The mandate will inevitably create a large group of Americans who are obligated to buy health insurance but who can't afford it. These

Patient Protection and Affordable Health Care Act of 2010

Table 2. Implementation schedule of ACA.

ISSUE	WHAT LEGISLATION WOULD DO	EFFECTIVE DATE
<b>2010</b>		
Business tax credits	Small businesses with no more than 25 employees and average annual wages of \$40,000 would receive tax credits to help provide insurance to employees. The tax credit would be up to 35% of the employer's contribution if the employer pays 50% of the total premium cost	2010 tax year, with the credit increasing up to 50% in 2014
Temporary reinsurance program	A \$5 billion temporary reinsurance program would be created for employees to provide health care coverage for retirees over the age of 55 who are not eligible for Medicare.	90 days after enactment
Temporary high-risk insurance pool	A \$5 billion temporary national high-risk insurance pool would be created to provide health coverage to individuals with pre-existing medical conditions who have been uninsured for at least six months.	90 days after enactment
Pre-existing conditions	Insurance companies would be barred from denying coverage to children who have pre-existing medical conditions.	Six months after enactment
Adult dependent children	Insurance companies would have to provide coverage for dependent children up to the age of 26	Six months after enactment
Insurance coverage limits	Insurance plans would be prohibited from placing lifetime limits on how much they pay out to individual policyholders and from rescinding coverage except in cases of fraud.	Six months after enactment
Medicare drug rebates	Medicare patients who face a gap in prescription drug coverage would receive a one-year, \$250 rebate to help pay for medication.	Immediately
Tanning salon tax	A tax of 10% would be imposed on the cost of indoor tanning services	Immediately
Preventive services	Health insurance plans would be required to cover preventative services such as immunization for children and cancer screenings for women.	Six months after enactment
<b>2011</b>		
Tax changes on health care savings accounts	The federal tax on individuals who spend money from health care savings accounts on ineligible medical expenses would double to 20%.	Jan. 1, 2011
Community health centers	Funding would increase by \$11 billion for community health centers that provide medical care to patients who can't afford it.	Oct. 1, 2011
Medicare "doughnut hole"	Drug companies would provide a 50% discount on brand-name prescription drugs for seniors who face a gap in drug coverage. More subsidies would be phased in through 2020, when the coverage gap would be closed.	Jan. 1, 2011
Primary Care	Primary care doctors and general surgeons practicing in areas that lack primary care doctors would receive a 10% bonus payment under Medicare.	Jan. 1, 2011 through 2015
Long-term care	A voluntary long-term care program called CLASS* would be created. After at least 5 years of contributions, enrollees would be entitled to a \$50-a-day cash benefit to pay for long-term care.	Jan. 1, 2011
New annual fee on drug-makers	A total annual fee of \$2.5 billion would be imposed on pharmaceutical manufacturers	Jan. 1, 2011
Insurance rebates	Health insurance companies would be required to provide rebates to enrollees if they spend less than 85% of their premium dollars on health care as opposed to administrative costs.	Jan. 1, 2011
<b>2012-13</b>		
Annual fee on drugmakers	The annual fee on pharmaceutical manufacturers would increase to \$3 billion each year through 2016.	Jan. 1, 2012
Contribution limits on health care savings accounts	The limit on how much individuals could contribute to flexible savings accounts that let people set aside money tax-free for health costs would be set at \$2,500. Currently employers set the limit.	Jan. 1, 2013
Itemized deductions for unreimbursed medical expenses	The threshold for deducting such expenses would increase from 7.5% of adjusted gross income to 10%.	Jan. 1, 2013
Medicare taxes	The Medicare tax rate would increase by 0.9 percentage points—from 1.45% to 2.35%—on earning over \$200,000 for individuals and \$250,000 for families. Also, for the first time, a 3.8% Medicare tax would be imposed on unearned income.	Jan. 1, 2013



Table 2 (cont.). *Implementation schedule of ACA.*

ISSUE	WHAT LEGISLATION WOULD DO	EFFECTIVE DATE
2014		
Individual mandate	Most Americans would be required to buy health insurance or pay fines of \$95 per individual up to \$285 per family or 1% of taxable household income, whichever is greater.	Jan. 1, 2014
Employer requirements	Companies with 50 or more employees would pay a fine if any of their full-time workers qualified for federal health care subsidies.	Jan. 1, 2014
Medicaid expansion	The program for low-income Americans under the age of 65 would expand by increasing the income eligibility to 133% of federal poverty, or \$29,327 for a family of four.	Jan. 1, 2014
Federal subsidies	Federal subsidies, which vary based on household income, would help offset the cost of buying insurance for Americans and legal residents who qualify.	Jan. 1, 2014
Annual fee on insurance companies	An annual fee totaling \$8 billion would be imposed on health insurance companies	Jan. 1, 2014
Health insurance exchanges	A state-based health care exchange – a marketplace where uninsured individuals and small businesses could comparison shop for insurance policies – would be created.	Jan. 1, 2014
2015-16		
Individual mandate	Penalties for not carrying insurance would increase to \$325 for each family member up to \$975 per family or 2% of taxable household income, whichever is greater	Jan. 1, 2015
Annual fee on insurance companies	The annual fee on health insurance companies would increase to \$11.3 billion.	Jan. 1, 2015
Individual mandate	Penalties for not carrying insurance would increase to \$695 for each family member up to \$2,085 per family or 2.5% of taxable household income, whichever is greater.	Jan. 1, 2016 (Adjusted for inflation after 2016.)
2017-18		
Annual fee on drugmakers	The annual fee on pharmaceutical manufacturers would increase to \$3.5 billion in 2017 and \$4.2 billion in 2018.	Jan. 1, 2017
Annual fee on insurance companies	The annual fee on health insurance companies would increase to \$13.9 billion in 2017 and \$14.3 billion in 2018.	Jan. 1, 2017
Excise tax on high-cost insurance plans	A 40% excise tax would be imposed on health care plans that cost more than \$10,200 for individual coverage and \$27,500 for family coverage.	Jan. 1, 2018

\* Community Living Assistance Services and Supports  
Source: Kaiser Family Foundation, White House, The Commonwealth Fund

subsidies are designed to assist in meeting the obligation, and they fall into 3 categories (8).

The first subsidy is an expansion of the existing Medicaid program to include every American whose income is under “133% or 138% of poverty.” In practical terms, in 2014, when Medicaid expansion takes place, individuals with incomes less than about \$15,800 or families of 4 with incomes less than about \$32,300 will become eligible for comprehensive, affordable health insurance.

The ACA changes present regulations and removes 3 requirements:

- 1) An income test;
- 2) An asset test;
- 3) Covered category status (children, pregnant women, or a person who is disabled).

Thus, under the ACA, there will now be a national uniform income qualification – having an income be-

low the “133% or 138% of poverty” level – and there’s no longer any requirement to spend other assets or to belong to a covered category. The philosophical change to Medicaid as an entitlement program is substantial. Medicaid changes from including only the “deserving poor” (for example, the aged, blind, disabled, children, some single parents, pregnant women) to including all, including the “undeserving poor” (able-bodied adults). This expansion of Medicaid eligibility is expected to provide health insurance to approximately 18 million additional Americans by 2019 (8).

The second of these subsidies, and the most discussed, is an extensive cost-sharing arrangement for health insurance purchased through new exchanges. The exchanges are designed to be state-run administrative organizations that will organize and approve health insurance plans being sold by the insurance in-

dustry and present those plans accurately as a form of “one-stop shopping” (8). The health insurance offered through these exchanges is primarily available to those without employer-provided health insurance. Despite the mandate to purchase insurance that covers all the required services, flexibility is available for choosing among plans that cover different fractions of the total cost of those services. The ACA defines 4 tiers of insurance based on the percentage of a person’s health care costs that are expected to be covered by the insurance itself. These levels are called in the legislation “bronze” (60% of the expected health care costs covered by the insurance), “silver” (70%), “gold” (80%), and “platinum” (90%). The “silver” plan is used as the reference plan in calculating how much subsidy is available to a purchaser (8).

The major impact of the exchanges will be the benefits from substantial federal subsidies (8). These subsidies are available to Americans whose income is up to “400% of poverty” (\$93,700 for a family of 4 in 2014). At “133% or 138% of poverty,” an individual is responsible for the cost of health insurance up to a level of 2% of their income. For incomes above this level, the maximum percentage of income that anyone should have to pay increases in steps to 9.5% of income at “400% of poverty.” Table 3 provides examples of the cost of insurance and contributions (21).

Further, the ACA also provides limits on the amount of out-of-pocket expenses that a family will have to bear, providing substantial additional value to families in the lower and middle income scales. Thus, for a

family with an income of about \$40,000 in 2014, these provisions increase the actuarial value of a typical silver health insurance plan by roughly another \$2,500 in addition to the \$12,000 premium subsidy, for a total subsidy of \$14,500. These exchanges are expected to enroll about 29 million Americans by 2019, with about 10 million of those being conversions from existing insurance coverage (8).

Finally, the third subsidy consists of temporary (2-year) tax credits to small businesses as an incentive to begin offering health insurance. The credit can be up to 50% of the employer’s contribution in businesses with fewer than 10 employees and an average wage under \$25,000. The credit declines with larger sizes and higher wages until it disappears at 25 employees or a \$50,000 annual average. There’s no legal mandate for employers to offer insurance; however, there are penalties for employers of over 50 persons who don’t offer insurance or whose insurance places too much of the cost on the employee. These penalties range from \$2,000 to \$3,000. These anticipated penalties are a substantial source of the revenue that is used to pay for the ACA (8).

### 2.3 New Insurance Industry Requirements

The ACA enacted a set of new insurance industry requirements that substantially alter the existing business model. The ACA requires insurers to issue policies to anyone qualified who applies, to renew policies without regard to the health status of the insured, to eliminate pre-existing condition limitations, and to require that rates in the exchanges and small group mar-

Table 3. Exchange cost sharing 2014.

Family Income		Cost of Insurance			
Amount	Percentage of Poverty	Total Cost	Individual Cost	Federal Subsidy	Subsidy Percent of Total
\$30,000	128	\$19,300	0	\$19,300	100
40,000	171	14,245	\$ 1,982	12,263	86
50,000	213	14,245	3,385	10,860	76
60,000	256	14,245	4,937	9,308	65
70,000	299	14,245	6,626	7,619	53
80,000	342	14,245	7,600	6,645	47
90,000	384	14,245	8,550	5,695	40
100,000	427	14,245	12,245	0	0

Source: Kaiser Family Foundation “Health Reform Subsidy Calculator” <http://healthreform.kff.org/SubsidyCalculator.aspx> (21)

Note: Based on purchase of the “silver” plan (70% actuarial value), family of 4, 45-year-old policyholder, medium cost area, health insurance policy cost of \$14,245 (estimated by Kaiser) in 2014.

\*A family with \$30,000 of income would qualify for Medicaid, which is not directly comparable to the Exchange Policies. It would not typically have premium costs and out-of-pocket costs vary by state. This figure is an estimate based on Medicaid having a value of 95% of the total cost of health care.

kets vary only based on age, the geographic area, family composition, and tobacco use, thus reducing adverse selection (8). "Adverse selection" is the term utilized to describe buying insurance when sick at the standard rate.

There are other requirements on the insurance industry including that at least 85% of the premiums they collect from large groups must be spent for medical care. The ACA also imposes new regulations for review processes for rate increases deemed excessive.

The actuary at the federal Centers for Medicare and Medicaid Services (CMS) estimates that the combined effects of the mandate, subsidies, and changes in the insurance industry will make health insurance available for up to 34 million more Americans and thereby reduce the number of uninsured to about 23 million by 2019.

## 2.4 Other Provisions

The ACA also incorporated multiple provisions including an improvement in the Medicare Part D benefit (the Medicare pharmacy program) at a 10-year cost of \$40 billion and increasing payment rates to primary care providers at a cost of \$8.3 billion.

## 3.0 IMPACT OF THE AFFORDABLE CARE ACT ON HEALTH CARE SPENDING

### 3.1 Facts

To conform to the President's stated objective, and to be politically palatable, health reform had to show that it wouldn't "increase the deficit" (8). The CBO on March 20, 2010, estimated the legislation would reduce the deficit by \$143 billion over the first decade and by \$1.2 trillion in the second decade (18,22). The CBO generally does not provide cost estimates beyond the 10-year budget projection because of the great deal of uncertainty involved in the data. Provided in this case at the request of lawmakers, it predicted a deficit reduction around a broad range of 0.5% of gross domestic product (GDP) over the 2020s while cautioning that a wide range of changes could occur (23). The deficit reduction number was modified by a subsequent CBO letter on May 11, 2010, that estimated the ACA would require about an additional \$115 billion to fund items not originally scored. At the time of the May 2010 letter (24) there still remained a further 53 line items that were also authorized but not yet scored. Table 4 illustrates the 10-year financial summary of uninsured coverage expansion provisions of the ACA.

Table 4. Financial summary of Affordable Care Act.

Source of Funds	\$ billions
Taxes and fines	\$517
Reduced payments to providers	368
Use of initial CLASS premiums	70
Other revenue and savings	133
Total source of funds	\$1,088
New Expenditures	
Medicaid expansion (with CHIP *)	\$434
Exchange subsidies	465
Small-employer tax credits	37
Overhead and other	47
Total New Expenditures	\$983
Expansion-related "deficit reduction"	\$105

\* Children's Health Insurance Plan

Sources:

Elmendorf to Pelosi, March 20, 2010

[www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf](http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf) (18);

Elmendorf to Lewis, May 11, 2010,

[www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr\\_HR3590.pdf](http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf) (24)

Joint Committee on Taxation, Estimated Revenue Effects of the Amendment, etc., Document JCX-17-10,

[www.jct.gov/publications.html?func=showdown&id=3672](http://www.jct.gov/publications.html?func=showdown&id=3672)

The CBO estimates have been criticized extensively and subsequent estimates have shown that these projections were not accurate (25-27). The CMS's economists recalculated their numbers in light of the health bill and now project that the increase will average 6.3% instead of 6.1% a year (25-27). This first federal government report on spending post-health reform projects a moderate impact of the ACA on overall health spending with projections reaching nearly \$4.6 trillion by 2019 (26,27).

A summary of NHE projections (26,27) is as follows:

- ◆ Health spending in 2010 has been projected to reach \$2.6 trillion and account for 17.5 percent of GDP, up 0.2 percentage points from pre-reform estimates. This growth is driven in large part by the postponement of cuts to Medicare physician payments and legislative changes to COBRA premium subsidies.
- ◆ In 2011, public and private health spending is expected to grow more slowly as reductions in Medicare physician payment rates (including a 23% reduction in December of 2010) come into effect and COBRA premium subsidies expire.
- ◆ Health spending is projected to rise significantly in 2014 when health coverage is expanded to mil-



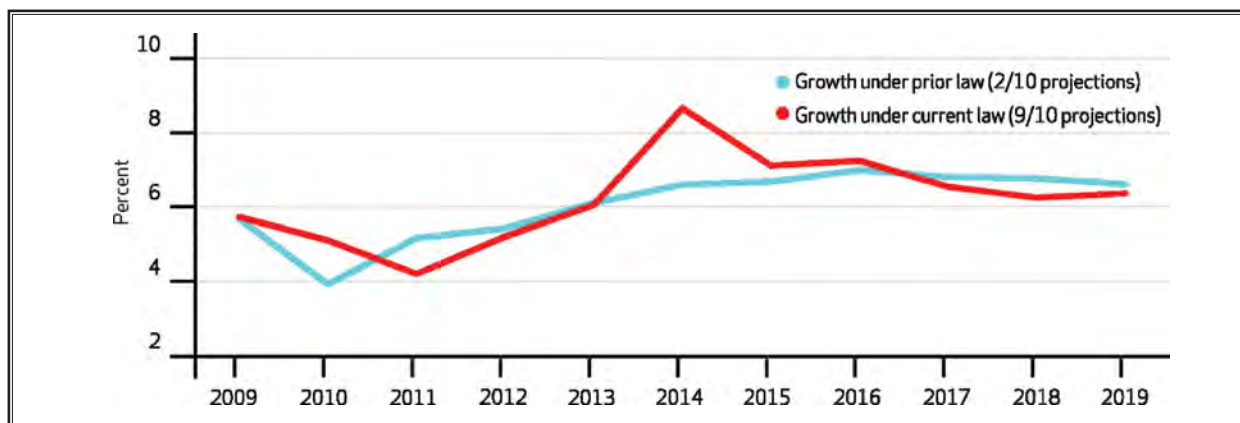


Fig. 1. Annual growth rates in national health expenditures (NHE) under current law (September 2010 projections) versus prior law (February 2010 projections), calendar years 2009–2019.  
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (26).

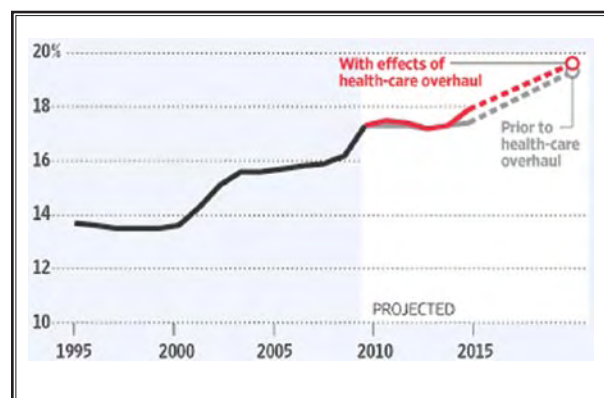
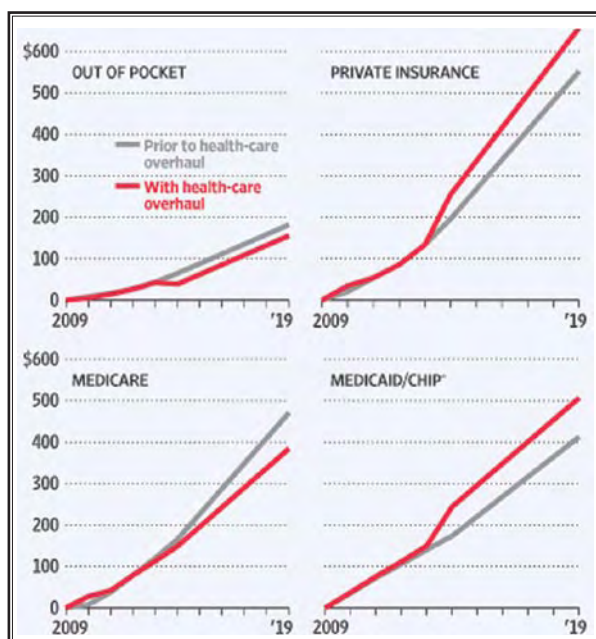


Fig. 2. Health care spending as a percentage of GDP.  
Source: Centers for Medicare and Medicaid Services; Health Affairs (26)



\*Children's Health Insurance Program

Fig. 3. Cumulative change in spending by source, in billions.

Source: Centers for Medicare and Medicaid Services; Health Affairs (26)

lions of uninsured Americans. Expanded coverage means overall spending is expected to increase by 9.2%, significantly higher than the 6.6% rate put forward in February. Public spending is projected to increase by 9.7% in 2014, while private spending is anticipated to increase by 8.6%.

- ◆ With more people insured in 2014, out-of-pocket spending is projected to decline by 1.1% instead of rising 6.4% as initially expected.
- ◆ From 2015 through 2019, NHE are projected to grow at an average annual rate of 6.7%, slightly less than the pre-reform projection of 6.8%. CMS analysts attribute this to a reduction in Medicare spending growth, which is projected to be 1.4 percentage points lower than pre-reform estimates.
- ◆ Figure 1 illustrates the annual growth rates in NHE

under current law versus the prior law for calendar years 2009 to 2019.

- ◆ Figure 2 illustrates the effect of the law with health care spending as a percentage of GDP.
- ◆ Figure 3 illustrates the cumulative change in spending by source.

### 3.2 Pros and Cons of Cost Estimations

The reports by federal officials (25-27) cast fresh doubts on the argument that the health care law would curb the sharp increase in cost over the long-term. The savings were calculated to be 1.4 percentage points because it contains lower payments to health care providers, an implementation of the sustainable growth rate (SGR) formula with cuts exceeding 45%, with the cost of the fix ranging from \$220 to \$330 billion (28-34). The CBO initially estimated the federal government's share of the cost during the first decade at \$940 billion, of which \$923 billion takes place during the final 6 years (2014 to 2019) when the spending actually starts kicking in, with revenue exceeding spending during the initial 6 years (18,35,36).

Later in 2010, after considering the multitude of issues reviewed, CBO, in its presentation on health costs and the federal budget (37), summarized that rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. They also expressed that the ACA does not substantially diminish that pressure. They concluded that putting the federal budget on a sustainable path would almost certainly require a significant reduction in the growth of federal health spending relative to current law (i.e., ACA).

Reinhardt (38), a health economist from Princeton, wrote that "the rigid, artificial rules under which CBO must score proposed legislation unfortunately cannot produce the best unbiased forecast of the likely fiscal impact of any legislation." He also stated that even if the budget office errs significantly in its conclusion, the bill would actually help reduce the future medical deficit. In fact, Gabel (39) from the Commonwealth Fund, commented that in contrasting actual spending with projected spending, the CBO, in all 3 cases of the prospective payment system for hospitals in the 1980s, the Balanced Budget Act (BBA) of the 1990s, and the MMA of 2003 (12,40), substantially underestimated savings from these reform measures.

However, others have disagreed with these remarks, showing examples of escalating Medicare costs 10 times above the projections and Social Security projections which also have been out of control. In addition, an analyst from the Center on Budget and Policy Priorities said that Congress has a good record of implementing Medicare savings. According to their study, Congress implemented the vast majority of the provisions enacted in the past 20 years to produce Medicare

savings (39,41,42). Capretta (29) considered the ACA as another runaway entitlement program without understanding the true cost of the legislation. He postulated that the reform might actually have an opposite effect and increase the health care costs and reduce coverage. A former CBO director, who served during the George W. Bush administration, estimated that the bill would increase the deficit by \$562 billion (43). In addition, a former US Comptroller General has stated that the CBO estimates are not likely to be accurate, because they are based on the assumption that Congress is going to do everything they say they are going to do (44).

Bredesen, a Democrat and supporter of President Obama, also felt that the ACA was a lost opportunity to control costs (8,45).

### 3.3 Influence of the State of the Economy

A weak economy slows down the growth in health care expenses (46). During 2009, a year of deep recession followed by slow economic growth, national health care spending rose at its lowest rate in 5 decades, with 4% growth in 2009 to \$2.5 trillion, or \$8,086 per person. This was even slower than the growth in 2008 of 4.7%.

The severity and length of the recession appears to have profoundly influenced health spending in 2009, contributing to a historically low rate of growth in private health insurance spending, slow growth in consumer out-of-pocket spending, and a decline in health care providers' investments in structures and equipment. During this period, a large number of people lost their health insurance and also had less income to devote to health care.

However, during the same period, federal spending grew quickly due to an injection of funding to Medicaid since 2000 as a result of the American Recovery and Retirement Act (ARRA) and the subsequent enrollment of 3.5 million additional people into Medicaid. Further, spending on prescription drugs grew faster than in the 2 previous years; 5.3% growth in 2009, versus 3.1% in 2008, and 4.7% in 2007.

Overall, despite the slowdown, health spending still outpaced the growth rate of the overall economy. As a result, health spending grew to 17.6% of the GDP in 2009, a full percentage point higher than the 16.6% in 2008 and the largest one year increase in the history of the national health expenditure accounts since 1960.

#### **4.0 THE IMPACT ON THE UNINSURED**

According to CBO estimates, the number of uninsured will be reduced by 32 million from current levels. Despite this seemingly impressive number, it will still leave 23 million citizens without health insurance after the act is implemented fully in 2019 (47-49). It also estimated that private insurance enrollment will rise steeply as a projected 15.8 million obtain coverage through the health insurance exchange plans in 2014 (26,27).

Newhouse (50), in assessing health reform's impact on 4 key groups of Americans showed that patients encompassing and eligible for Medicaid or Children's Health Insurance Plan (CHIP), or who are currently uninsured, constitute approximately 30% of the U.S. population (in 2009). This nets approximately 16% of the U.S. health care spending. Reform is impactful in that it is a major gain based on Medicaid's eligibility expansion. Even though this issue raises fiscal, administrative, and delivery system issues, the supporters believe that it can be achieved and beneficial.

In addition, people with individual or small group insurance are also expected to benefit by being added to the insurance rolls. This group is estimated to be approximately 5% of the population, or 15 million people, and includes those with individual and small-group insurance purchased by firms with fewer than 50 employees. Many of them are currently uninsured and are not eligible for Medicaid. Some have pre-existing conditions. Such insurance exemptions banned in the future and health insurance will be available to individuals through exchanges. Some people who are currently insured but suffer from "job lock" (hesitant to switch employers because they fear losing their benefits) might move from large firms to self-employment or to small firms that do not offer insurance.

However, this evaluation does not consider that employers who provide insurance now might elect not to do so and pay penalties (8,45). As many as 20 to 80 million employer insured individuals could lose this coverage, and some might enroll in exchanges (8,45,51). Further, the effects of recession and health insurance coverage have not been taken into consideration (47-49). Additionally, at an individual mandate level, there are those who suggest that patients will elect to not accept coverage and pay the penalty as it will be cheaper than insurance alternatives.

#### **5.0 EFFECT ON NON-MEDICARE HEALTH INSURANCE PREMIUMS**

While administration officials touted a \$2,500 reduction in premiums for each individual (52,53), others have estimated that premiums will increase significantly. In fact, some have stated that the effect of increased premiums is already being felt due to the mandated coverage for pre-existing conditions and the addition of children up to age 26 onto the parents' policies that have already taken effect in 2010.

However, these assumptions and projections might be inaccurate. In addition, numerous pilot programs which will be taking effect have not been taken into consideration by the CBO in their estimates. These programs could in fact reduce the costs of health care, but they themselves are expensive and the results are not immediately visible. Further, the Office of the Actuary at CMS in their report released in April 2010, projected that the ACA would increase the number of Americans with health insurance coverage but would also increase projected spending by approximately 1% over a period of 10 years (54). Based on these estimates, the increases could be larger because the Medicare cuts in the law may be unrealistic and unsustainable (i.e., physician payment reform, etc.). These cuts might have a significant effect on access for Medicare patients with a number of physicians deciding not to accept them; 15% of hospitals and other institutional providers could be put into debt (54,55).

Following the passage of the act, several employers took multiple actions. For example, AT&T, Caterpillar, Verizon, and John Deere issued financial reports showing large current charges against earnings (up to \$1 billion in the case of AT&T), attributing the additional expenses to tax changes in the new health care law (56). This is based on the provision in the new law prohibiting companies from deducting a subsidy for prescription drug benefits granted under Medicare Part D (57). Thus far, the Department of Health and Human Services (DHHS) has granted over 222 companies waivers from participation in the program (58).

In contrast to CMS estimates of lower out-of-pocket expenses, it has been suggested that about one in 4 covered workers now face annual deductibles of \$1,000 or more, including nearly half of those employed by small businesses (59). It has also been shown that family health premiums rose 3% to \$13,770 in 2010, but workers' shares jumped 14% as firms shift the cost burden. Table 5 illustrates premiums under the ACA for 2016

Table 5. *Premiums under ACA*

Type of Plan	Current	2016	
		With Bill	Without Bill
Large Business	\$13,375	\$20,100	\$20,300
Small Business	\$13,375	\$19,200	\$19,300
Individual Policy	\$6,328	\$15,200	\$13,100

Source: Current cost of health insurance policy based on America's Health Insurance Plans' (AHIP) data; future estimates based on Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Sen. Evan Bayh, November 30, 2009 (60)

with increases for individual policies (60). However, these estimates appear to be low, as multiple insurers increased premiums by 50% for 2011.

Workers on average are paying nearly \$4,000 this year toward the cost of family health coverage - an increase of 14%, or \$482, above what they paid last year, according to the benchmark 2010 Employer Health Benefits Survey by the Kaiser Family Foundation and the Health Research & Educational Trust (HRET) (61). It was also shown that workers' contributions to premiums have gone up 47%, while overall premiums rose 27%, wages increased 18%, and inflation rose 12%, since 2005.

## 6.0 IMPACT ON MEDICARE AND MEDICAID

President Barack Obama on June 8, 2010, stated that the ACA is expected to keep Medicare strong and solvent - today and tomorrow (62). The ACA includes a series of Medicare reforms that will generate billions of dollars in savings for Medicare and strengthen the care Medicare beneficiaries receive (62). The new law is expected to protect guaranteed benefits for all Medicare beneficiaries, and provides new benefits and services to seniors on Medicare that will keep seniors healthy. Other aspects of ACA in relation to Medicare include improved quality of care, development in promoting new models of care delivery, appropriate pricing of services, modernization of health system, and fighting waste, fraud, and abuse. They conclude that with implementation of these changes the life of the Medicare Hospital Insurance Trust Fund is increased by 12 years from 2017 to 2029, more than doubling the time before the exhaustion of the trust fund (63). CMS claims that the Medicare savings will lower beneficiaries' Part B premiums by nearly \$200 annually by 2018 (Fig. 4). CMS also argues that, historically, Medicare has often led the entire health care system in the adoption of

quality and payment innovation. They show examples as Medicare's physician fee schedule, diagnosis related groups (DRG) for inpatient hospitals, and risks-adjustment systems for private plans encouraging quality and efficiency. Consequently, they claim that the ACA ensures that Medicare will continue to serve as a leader in driving the widespread adoption of innovative quality and payment strategies.

However, it has been the intention of the ACA that private payers will follow the cuts Medicare is imposing on providers. Based on the savings they project, both with and without the passage of ACA, Medicare spending was projected to grow at an average annual rate of 6.8%, reaching an annual cost of roughly \$978 billion by 2019, and then be reduced 5.3%, reaching \$852 billion by 2019 (Fig. 5).

According to opponents of the ACA (28,64), it empowers bureaucratic micromanagement and price regulation and makes the program's current problems even worse. Moffit (28) described that under the ACA, there are well over 100 sections of the law dealing with various aspects of Medicare programs, ranging from changes (mostly reductions) in payments for physician services, for hospitals, for skilled nursing homes, and home health care agencies, and Medicare Advantage Plans. Several provisions have direct impact on the practice of medicine by essentially increasing the federal supervision of medicine that was explicitly rejected when Medicare was enacted in 1965, and removing the professional independence of the medical profession. Davis (65) in an April 21, 2010, report observed the following:

"(The law) makes several changes to the Medicare program that have the potential to affect physicians and how they practice in ways both small and large, immediately and over time. While some of the provisions have clear and direct consequences, for instance

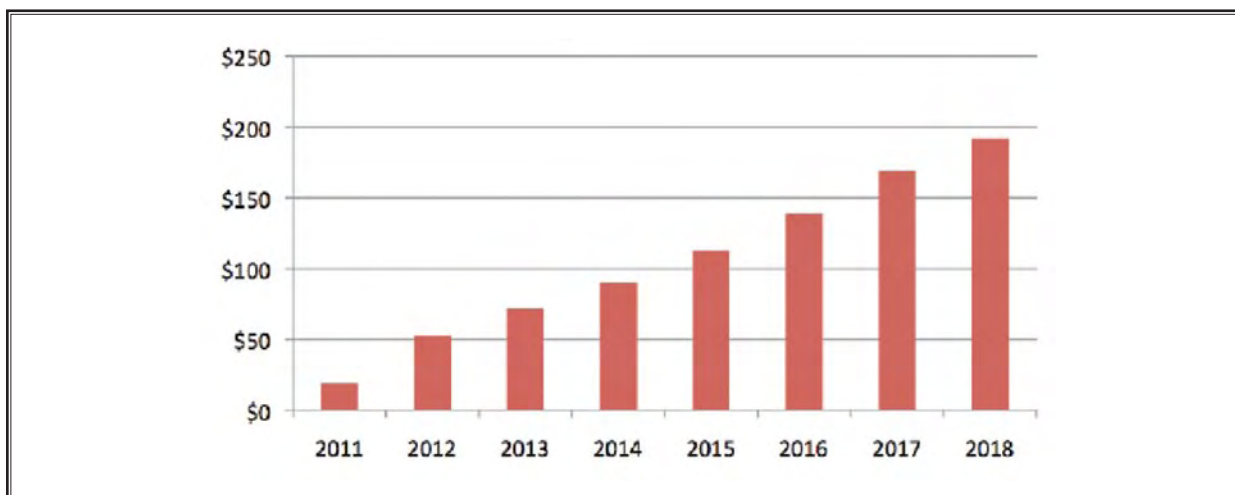


Fig. 4. Savings in annual Part B premium (63).

Source: CMS Office of the Actuary, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act’ as Amended” (2010).

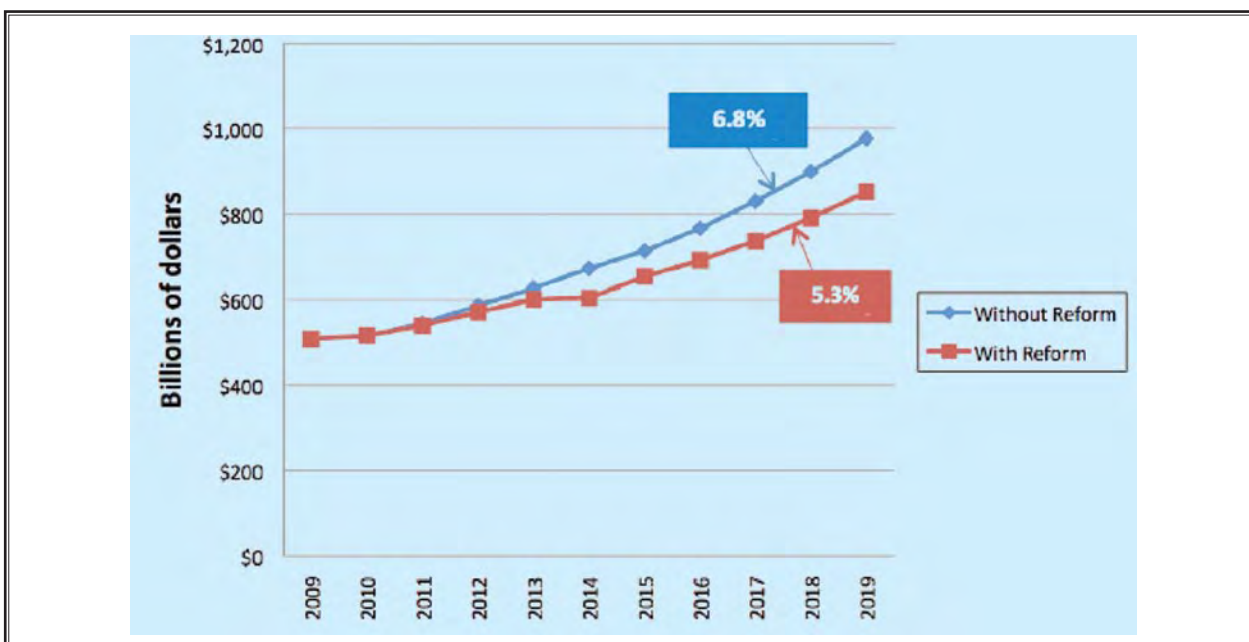


Fig. 5. Medicare spending with and without reform, 2009-2019 (63)f

Source: Analysis based on data from the CMS Office of the Actuary’s April 22, 2010 Memo.

altering physician reimbursement right away, others have the potential to influence how physicians might practice in the future by changing the incentives to encourage improvements in the organization and delivery of care.”

In addition, Foster (66), Chief Actuary of CMS, in his analysis accompanying the Annual Report of the Medicare Board of Trustees, noted that Medicare payment rates for doctors and hospitals serving seniors will be cut by 30% over the next 3 years. Further, while the ACA,



as amended, makes important changes to the Medicare program and substantially improves its financial outlook, there is a strong likelihood that certain of these changes will not be viable in the long range. He further reported that, specifically, the annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in economy — wide productivity. The best available evidence indicates that most health care providers cannot improve their productivity to this degree — or even approach such a level — as a result of the labor-intensive nature of these services. He also noted that under the policies of the ACA, by 2019, Medicare payment rates will be lower than under Medicaid. Further, he noted that by the end of the 75-year projection period in the Annual Medicare Trustee Report, Medicare payment rates will be one-third of what will be paid by private insurance, and only half of what is paid by Medicaid.

Medicare Advantage Plans will have a significant impact on the Medicare budget and seniors. Since the 1970s, Medicare beneficiaries have had the option to receive Medicare benefits through private health plans, mainly health maintenance organizations (HMOs), as an alternative to the federally administered fee-for-service Medicare program. However, the BBA of 1997 (40) named Medicare's managed care program "Medicare Plus Choice" and the MMA (12) of 2003 renamed it "Medicare Advantage." Medicare payments to plans are estimated to total \$116 billion in 2010, accounting for 22% of total Medicare spending.

Over the course of the past several decades, Medicare payment policy for plans has shifted from one that produced savings to one that focused more on expanding access to private plans under Medicare and providing extra benefits to Medicare private plan enrollees. These policy changes resulted in Medicare paying private plans more per enrollee than the cost of care for beneficiaries in the fee-for-service program. According to MedPAC, payments to Medicare Advantage Plans per enrollee averaged 109% of the fee-for-service costs in 2010.

The ACA reduces the federal payments to Medicare Advantage Plans over time, bringing them closer to the average costs of care under the fee-for-service Medicare program. The law also provides new quality bonus payments to plans beginning 2012, and beginning in 2014, will require plans to maintain a medical loss ratio of at least 85%, restricting the share of premiums that Medicare Advantage firms can use for administrative expenses and profits.

In 2010, the majority of the 47 million people on Medicare were on the fee-for-service Medicare program, with 24% enrolled in a Medicare Advantage Plan.

Reduced cost-sharing has been described as the most common benefit of Medicare Advantage Plans. Between 2008 and 2010, the average cost-sharing increased for both inpatient and outpatient services (67). It is expected that premiums will increase and force many out of the program. In contrast to the reports, Medicare Advantage patients have been spending more on prepay prior to an office visit or a minor surgical procedure than actual fees and associated deductibles even though there is a cap of \$6,700 with most patients not reaching the cap and insurers benefiting from this activity.

With regards to Medicaid and physician payments, many providers believe that when Medicaid patients enter their waiting rooms, the physicians or the hospitals are not competitively using their time (68). Even though there is a scheduled increase in Medicaid reimbursement for primary care physicians, there is no structural change in the new law benefiting all physicians or altering the dynamics of the current Medicaid payment system.

Estimates from the CBO suggest that Medicaid will add 16 million enrollees, 50% of the expected 32 million to Medicaid that will be covered. However, for the administration, the silver lining is that the effect of Medicaid expansion would appear to be easier to predict than individual mandates. The expanded coverage will be free to the states, at least through 2016, and to uninsured persons whose income qualifies them for it, and it has been projected that almost all individuals who are eligible will enroll. However, it is well known that eligibility for health insurance does not always translate into actual enrollment — as evidenced by the millions of uninsured adults who are already eligible for Medicaid under current law (68).

There are multiple other regulations impacting Medicare and Medicaid in the health care law. One is the 15-member IPAB board to make Medicare payment policy (28). The board's task is to make recommendations to reduce the per capita growth rate in Medicare spending. Unless Congress enacts alternatives to affect the same level of savings, the Secretary of HHS, and presumably, the CMS Administrator, are to implement the board's recommendations. Unlike much of the broad grants of authority to the Secretary of HHS, the statutory language is uncommonly prescriptive (28). By

2015, Medicare payment is to grow at the rate of health care inflation. By 2019, it is to grow at GDP plus one percentage point. In the past 20 years, CBO estimated that Medicare's average annual rate of growth was 8%. Consequently, it is a definite issue for providers to understand that the board can indeed cut reimbursements to physicians and other medical professionals to hit these ambitious savings targets, as measured by inflation and GDP. Curiously, hospitals, which account for the largest portion of Medicare spending, are exempt from the board's authority until 2019.

Another law affecting physicians is the Physician Quality Reporting Initiative, or PQRI (69). The program is to improve the quality of care delivered to Medicare patients. If doctors report the specified quality data, meaning that they are complying with federal standards in the delivery of care, they get Medicare bonus payments. If they do not reply and do not report the required data, their Medicare payments are cut (69). By 2015, the law makes participation compulsory for participating physicians in Medicare.

Under the ACA, CMS officials will also be charged with designing 20 new payment systems for physicians. The statute specifically calls for the reduction of Medicare payments away from traditional fee-for-service, which serves about 77% of seniors today, in favor of salaried physician payments (70). The bundling of payments or accountable organizations are mostly in favor of the hospitals and could result in limitations in the practice of independent medicine.

## **7.0 ADMINISTRATIVE SPENDING AND REGULATIONS**

Regulation shapes all aspects of America's health care system, from the flow of dollars to the communication between physicians and patients. It has been well known that health care regulation in America is complex. Government agencies at the federal, state, and local levels direct portions of the industry, but hundreds of private organizations do as well. In 2004, Conover (71) provided an overview policy analysis of health care regulation as a \$169 billion hidden tax. In 2004, Conover reported that the burden of regulation on the U.S. economy is sizeable, with the largest figures suggesting this cost could approach \$1 trillion in 2004. Not surprisingly, the health care industry is one of the most heavily regulated sectors of the US economy. Regulators continue to ignore the cost of regulating health care services and instead increase them. Utilizing a bottom-up approach, Conover (71), suggested that the

total cost of health services regulation exceeds \$339.2 billion. After subtracting \$170.1 billion in benefits, the net burden of health services regulation accounted for \$169.1 billion annually in the 2004 estimation. In other words, he estimated that the cost of health services regulation outweighed benefits by 2-to-1 with a cost to the average household of over \$1,500 per year. In 2004, Conover estimated that the high cost of health services regulation was responsible for more than 7 million Americans lacking health insurance, or one in 6 of the average daily uninsured. Further, approximately 4,000 more Americans die each year from costs associated with health services regulation (22,000) than from lack of health insurance (18,000).

In October 2009, a Thomson Reuters report showed that the health care system wastes between \$505 billion and \$850 billion every year, an estimated one-third of the nation's health care bill (72). This report indicates that health care waste can be attacked and health care costs can be reduced without adversely affecting the quality of access to care. This report shows that elimination of a paper-based medical record system will save 6% of spending; overuse of antibiotics and lab tests to protect against malpractice exposure makes up 37% of health care waste, or \$200 to \$300 billion a year.

Allegedly, fraud makes up 22% of health care waste, or up to \$200 billion a year in inappropriate Medicare claims, kickbacks for referrals for unnecessary services, and other scams. Further, administrative inefficiency and redundant paperwork account for 18% of health care waste. Medical mistakes account for \$100 billion in unnecessary spending each year, or 11% of the total. Preventable conditions such as uncontrolled diabetes cost \$50 billion a year. This report also showed that the average U.S. hospital spends one quarter of its budget on billing and administration, nearly twice the average in Canada. In addition, American physicians spend nearly 8 hours per week on paperwork and employ 1.66 clerical workers per doctor, far more than Canada (73).

Many consider health care reform will regulate health care in the United States further, which is already highly regulated. Additional regulations are expected to increase costs. At present, ever increasing regulatory requirements, in addition to existing regulations such as Health Insurance Portability and Accountability Act (HIPAA) which has been estimated to exceed \$1 trillion by 2019 (74), BBA (75), MMA (12), new regulations under ARRA (75,76), administrative regulations of ASCs (77), ICD-10 with an estimated cost of \$83,000 for a small practice of 3 physicians

and almost \$3 million for large practices (78), EMRs (79), and many others (75,76) are overwhelming to the providers and patients with increasing costs.

Antos (80) described that a highly regulated approach to health care reform is unlikely to reduce costs or improve outcomes. The fundamental issue is that government experts will decide when an insurance plan is not good enough or a treatment is not effective enough. Many believe that regulations in the new law are expected to reduce physician independence, patient choices, and eliminate personalization of medicine (81).

In addition, it has been shown that the estimated national time cost to practices for interactions with insurance plans is at least \$23 billion to \$31 billion each year (82-84). It also has been estimated that for a physician the costs of prescription writing and refills ranges as high as \$20,000 per year (85). Administrative complexity and billing issues (83,84) cost the health care system at least \$7 billion per year, with doctors spending 200 hours of professional time and 250 hours of practice support staff time. Of concern, the regulations in the ACA might actually increase many of these costs. With reference to accountable care organizations, the role of patients has not been fully defined even though the ACA promises to expand health insurance coverage. Further, issues remain with regards to physicians versus hospitals as leaders of accountable care organizations and the result on individual physician practices in the United States (86).

Finally, the importance of regulations also lies in numerous boards issuing regulations without congressional approval, one of which is the IPAB (87). This regulation is based on a common theme in the health care reform debate in recent years that there is a need for a board of impartial experts to oversee the health care system. This board is thus vested with enormous powers. Similar issues were raised concerning the Patient-Centered Outcomes Research Institute (PCORI) (88-96).

## **8.0 IMPACT ON PRACTICE OF MEDICINE**

The ACA will make health insurance available to an additional 34 million Americans (8). This is probably the best policy of the ACA and should provide many more patients with insurance. However, while insurance might be provided, the coverage for many procedures will be either diminished or eliminated. Further, concern exists that the regulatory involvement will adversely affect the practice of medicine.

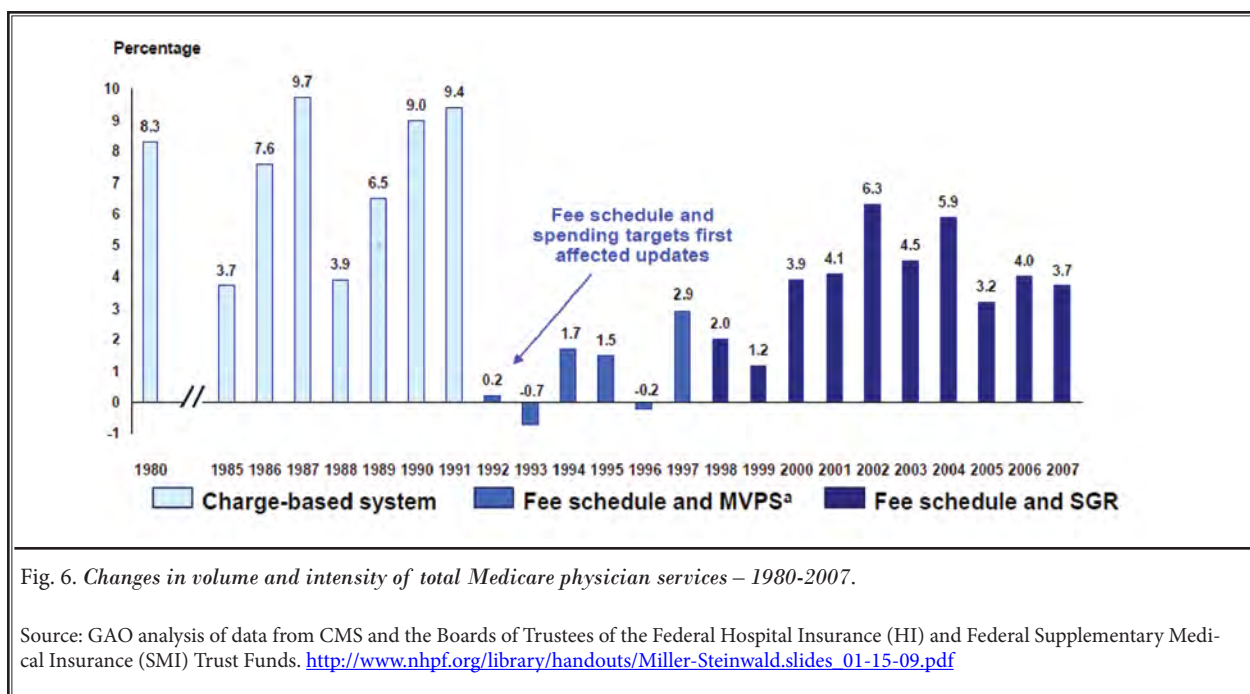
As Moffit (28) has described that professional independence could be affected by fundamentally altering

the relationship between individual Americans and the federal government. This is a result of the imposition of individual/employer mandates and regulations in a highly prescriptive fashion associated with the financing and delivery of health care in the United States. Moffit (28) also emphasized Berwick's philosophy of rationing with eyes open. Moffit believes that a common impression among ordinary Americans is that medical professionals have professional independence and federal interference is inaccurate. In reality, that independence has been gradually eroded. Under the BBA of 1997 (40), Congress enacted for the very first time a unique statutory restriction on the ability of doctors and Medicare patients to contract privately with each other for the delivery of medical services outside of the Medicare program.

The Congressional Research Service in its April 21, 2010, report (65) observed that the law makes several changes to the Medicaid program that have the potential to affect physicians and how they practice in ways both small and large, immediately and over time. The report also adds that while some of the provisions have clear and direct consequences, for instance altering physician reimbursement right away, others have the potential to influence how physicians might practice in the future by changing the incentives to encourage improvements in the organization and delivery of care.

One of the biggest challenges in evaluating the ACA involves cost estimations, savings, and implementation related to the Medicare SGR formula. Inconsistencies are enormous, with expenses not being taken into consideration, and then projected as savings. Under that formula, if the Medicare physician payment exceeds the growth of the economy, the Medicare physician payment is automatically reduced by a proportional amount (97-104). While the congressional leadership has indicated a strong desire to repeal the current Medicare SGR payment update formula, it is still unclear how they intend to do it without increasing the deficit, the cost of which is estimated at around \$250 billion. With continued congressional enactment of temporary "doc fix" patches, physicians are increasingly demoralized by the recurrent problem.

The SGR formula, which is in effect now, continues to hamper physician payments. Since 2002, spending (as measured by the SGR method) has consistently been above the targets established by the formula (105-113). Figure 6 illustrates changes in the volume and intensity of total Medicare physician services from 1980 to 2007 (113).



The SGR reduction in payment rates for physician services resulted in a cut of 4.8% in 2002, with CMS deciding on sustained cuts of 4.4% in 2003 and beyond. However, in 2003, Congress responded by increasing payments for physician services by 1.6% instead of a projected 4.4% cut (12,114). In 2004 and 2005, the MMA replaced the scheduled rate reduction with an increase of 1.5%. In 2006, the Deficit Reduction Act (DRA) held 2006 payment rates at their 2005 level, overriding an additional impending 4.4% reduction (115). In 2007, Congress again approved holding the 2008 payments at the 2005 level, thereby avoiding an additional proposed 5.1% reduction (116). From 2008 to 2011, temporary measures were also undertaken (109). If the temporary measures were not undertaken starting January 2011, the cuts would have been 24.9% to 30.8% (108). The Medicare and Medicaid Extenders Act of 2010 (117) converted SGR with a 0% update. It should be noted that there have not been any significant raises since the SGR was first implemented. The CMS issued an emergency regulation with payment update with a 7.9% reduction in the conversion factor from \$36.8729 to \$33.9764 (109). The program, which is in obvious flux, and the formula which have been revised, has been utilized as a savings and deficit reduction measure in affordable health care law cost estimations and savings. There are challenges with the use of the SGR in this calculation.

The Association of American Medical Colleges (AAMC) projects a shortage of 150,000 physicians within the next 15 years, while 15 million seniors will enroll in Medicare over the next 10 years (118). At the same time, the ACA is encouraging other professionals such as nurse practitioners and physician assistants to take a major role in providing health care to Americans (119-121). The hope of policy experts is that these non-physician practitioners will primarily focus on primary care. These practitioners will at times seek to practice advanced specialties such as interventional pain management and maybe even surgery in the future (122-150).

The major impact on physicians of the ACA is related to IPAB and health care price controls (28,87,151-154). The President has described the IPAB as MedPAC on steroids, thus many question the necessity for this. Many organizations, including the AMA, which has supported the ACA, oppose the IPAB.

The legislation established specific target growth rates for Medicare and charges the IPAB with ensuring that Medicare expenditures stay within these limits. The IPAB must also make recommendations to Congress as to how to control health care costs. More generally the IPAB will have 15 members appointed by the president for 6-year terms, supplemented by 3 officials representing the DHHS. IPAB members are supposed to be nationally recognized experts in health finance,

Table 6. *Three-year sequence of events.*

<b>Determination Year (DY)</b>	
By April 30	Chief Actuary of CMS makes projections and determination
By September 1	Draft proposal sent by IPAB to MedPAC for consultation Draft proposal sent by IPAB to Secretary for review and comment
<b>Proposal Year (PY)</b>	
By January 15	Proposal submitted by IPAB to Congress and the President
By January 25	Secretary submits own proposal to Congress and the President, with a copy to MedPAC, if IPAB was required to submit a proposal but failed to do so
By March 1	Secretary submits report containing review and comments to Congress on IPAB proposal (unless the Secretary submitted own proposal because IPAB failed to do so)
By April 1	Deadline for specified congressional committees to consider the submitted proposal and report out legislative language implementing the recommendations. Congress has the authority to develop its own proposal provided it meets the same fiscal requirements as established for the Board and meets this deadline.
Beginning August 15	Secretary implements the proposal subject to exceptions
On October 1	Recommendations relating to fiscal year payment rate changes take effect
<b>Implementation Year (IY)</b>	
On January 1	Recommendations relating to Medicare Part C and D payments take effect Recommendations relating to calendar year payment rate changes take effect

Source: CRS analysis of P.L. 111-148 as amended (7).

payment, economics, actuarial science, or health facility and health plan management and to represent providers, consumers, and payers. The ACA appropriated \$15 million for the IPAB for 2012 and increases its funding at the rate of inflation for the subsequent years. Thus IPAB not only will affect Medicare payments, but also the entire health care industry. The purpose of the IPAB is to reduce the per capita rate of growth in Medicare spending indefinitely. It should be noted that in most years Medicare's per capita growth has been below or equal to growth in the private sector. The IPAB reductions would be in addition to the approximately \$500 billion savings in provider payments already included in health care reform legislation, which could jeopardize both access for Medicare beneficiaries and even infrastructure for the broader health care system. There is no congressional authority over this board. However, the CBO concluded in its analysis of the ACA that the IPAB would reduce Medicare spending by \$28 billion over the period from 2010 to 2019, with significant savings continuing beyond 2019.

IPAB will operate as follows: if the actuary of the CMS determines that Medicare expenditures will exceed a target rate of growth, the IPAB is required to develop proposals to save costs to achieve a minimum reduction in excess expenditures. The target rate of growth is set out in the law, for years prior to 2018, as the average of the consumer price index for all urban

consumers (CPI-U) and the medical care competence of CPI-U. In addition, for years 2018 and thereafter, the target rate growth is set as the GDP plus 1%. If these growth targets are exceeded, the proposals developed by the IPAB must be designed to achieve savings targets, which Congress specified as the lesser of the excess growth rate (projected growth minus target growth) or a defined percentage of the program spending (0.5% in 2015, 1.0% in 2016, 1.25% in 2017, and 1.5% in 2018 and beyond) (116). Table 6 illustrates a 3-year time horizon for IPAB proposals (7,151).

The National Commission on Fiscal Responsibility and Reform, appointed by the president, also endorses multiple aspects of the ACA (155). The draft proposal recommends speeding up cuts to Medicare Advantage and charity care payments to hospitals, both provisions in the ACA. The proposal calls for a much stronger IPAB, which already has been criticized. The commission also recommends replacing Medicaid payments with a "capped allotment." In addition, the commission calls on seniors to pay more towards their health care, calling for "expanding cost sharing."

The PCORI focuses on comparative effectiveness research and provides impressions about the effectiveness of various modalities without taking into account cost-effectiveness and that safeguards are provided with it cannot be used for denial of coverage, etc. However, as soon as the reports are released,



the coverage determinations are made, mostly negatively. Thus, PCORI is equivalent to National Institute for Health and Clinical Excellence (NICE) in the United Kingdom (88-90,92-96). Interestingly, the role of NICE in the National Health Service (NHS), which is highly prescriptive, has been questioned. NHS essentially is turning away from NICE and attempting to empower physicians in a major shift in the policy since its inception (156-171). In addition, Cochrane reviews, NICE, AHRQ, and other organizations are becoming commercialized with limited clinician input and methodologically focused evaluations, essentially creating a shadow governance of health care.

Interventional pain management as an evolving specialty has faced significant problems with these evaluations (89-96,172-191). Specifically challenging has been the inability to question the judgment of the methodologists, even though there is substantial evidence of effectiveness of some of the techniques (192-240). Finally, PCORI has included in their membership only a few clinicians, even though there are multiple medical doctors who function as administrators and methodologists.

## **9.0 THE PRESENT STATE OF THE ACA**

### **9.1 Cost Control**

Of all the arguments about the ACA, cost control has been one of its major motivations. Supporters of the act argue that even from a purely "green eye shade" viewpoint, the bill will significantly reduce costs (127). The projection suggests that with reform, total health care expenditures as a percentage of the GDP will be 0.5% lower in 2030 than they would otherwise have been. Indeed, the Commonwealth Fund projected that expenditures for the whole health care system will be reduced by nearly \$600 billion in the first decade (241). Even so, these analysts acknowledged that these savings will be illusory if health care delivery to bring down the long-term growth in costs is not implemented, and if we do not follow the ACA's path to doing so.

However, Bredesen (8) differs with the supporters and believes that the ACA does not fix the finances of our health care system - neither public nor private. Further, he describes that America is on a dangerous collision course with fiscal reality that we can't ignore much longer. He argues further that the cost control estimates are unrealistic as employer sponsored insurance will be changing and many people will be enrolling into exchanges. In addition, the growing bureaucracy and

control will increase costs. Bredesen believes that costs must be controlled by changing multiple components including drug pricing.

The CBO, in their scoring of the ACA, considered that one of the significant ways of paying for expanding health insurance coverage was the use of premiums from the new Community Living Assistance Services and Supports (CLASS) Act entitlement that was established. In this proposal, the legislation begins collecting premiums for this insurance in 2015, but doesn't begin paying out benefits until 2020, which is outside of the CBO 10-year time horizon (8,16,29,31,32). The CBO scoring of the legislation takes those first 5 years of premiums and drives them to paying for its expansion and coverage. The diversion represents \$70 billion of the offsets to the costs of the legislation. It also assumes that when it becomes necessary to begin paying benefits in 2020, there will be other premiums from other Americans to cover the cost. The challenge of these assumptions seems obvious, relying on what is essentially a flawed formula. (8).

The second issue is related to the credit of \$198 billion savings from reducing Medicare provider rates in future years. This is widely opposed by the physician community and has never been realized in the past (8,16,28,29,31-33,101-117).

Essentially, it appears that the ACA was made politically acceptable by setting up a series of challenging assumptions (8). When the CBO announced that the legislation would indeed reduce the deficit, the political path to passage was cleared, however, if proper adjustments are made and CLASS Act funds and "doc fixes" are taken out, and also add an additional \$115 billion to the cost of the legislation which was provided by the CBO in May 2010, it appears that the ACA will increase the deficit rather than reduce it (8,16,28,29,31-33).

### **9.2 Public Opinion**

Despite the fact that the law has already started taking effect, public opinion remains against the aggregate of what is known as health care reform. Critics of the ACA continue their campaign with doubts about its cost-containment measures and overall fiscal impact. The results of the 2010 midterm elections represent a wake up call for the political class. The midterm election results in part reflected public perceptions about the health care legislation. However, the opposition of the public did not freshly manifest itself at the time of these elections. Of 10 polls conducted just prior to the passage of the bill, none found a majority in support.

Three found about equal opposition and support, 5 found a plurality expressing opposition, and 2 found a majority expressing opposition (242). However, some of the ideas which showed majority support, such as purchasing drugs from Canada, limiting malpractice awards, and reducing the age to qualify for Medicare, were not enacted.

Apart from the results of the midterm elections, after the bill was passed, some polls reported that 55% of likely voters favored repealing the bill (243), whereas some polls reported that Obama's approval rating improved (244,245). Even then, as shown by CBS News, only 34% of Americans approved of President Obama's handling of health care and 32% approved of the health care bill signed into law (246).

On the eve of the Republican vote in the House on repealing health care reform, the United States continues to be split on repeal of the health care law, but it appears that Republicans have the fuel for roll back (247). USA Today (247) reported that Americans are closely divided over whether the new Republican-controlled House should vote to repeal the health care law that was enacted just last year. However, partisans on both sides are united, with Republicans solidly backing the repeal and Democrats overwhelmingly wanting the law to stand (248). A Gallup Poll conducted and published on January 8, 2011, (248) showed that independents are evenly split on the issue; however, political parties are united with their stand on the health care law. This poll showed that 46% of those surveyed say they want their representative to vote for repeal, in contrast to 40% who want the law to stand. While 80% of the Republicans support repeal, only two-thirds of the Democrats want the law to stay in effect. However, Independents are inclined to support the repeal, but by a margin too small to be statistically significant.

Most do not believe that the health law will be repealed with no path in the Senate and near certainty that the President would not sign a repeal law that would destroy one of his administrations singular legislative accomplishments. Nonetheless, the repeal vote is likely to be followed by months of efforts to chip away some provisions of the law and to deny other provisions the federal funding they need to be implemented. In support of the health care law, the CBO has issued a statement that repeal would result in an increase in the national debt by about \$230 billion from 2012 to 2021; however, these results have been challenged because of the underlying methodologies. (249).

### 9.3 Health Insurance Premiums

Several health insurers stated that they are seeking rate increases as a direct result of the law or unrelated to the ACA (250-258). The rate increases applied mostly to employees of small businesses of less than 50 people and to people who buy plans as individuals. It has been estimated that some customers could experience rate increases of over 20% (259). However, the administration stated that insurers had already planned to raise rates and were using the bill as an excuse. In addition, some insurance companies also announced that in response to the law, they would end the issuance of new child-only policies (260,261).

The DHHS informed health insurers that raise premiums 10% or more that they will face new regulator scrutiny (262). This is the latest effort to show that the ACA is helping tame rapidly rising rates. The new rules stop short of giving federal regulators the power to block increases, but they mark an expansion of federal oversight in an area traditionally controlled by the states. Insurers have accused the Obama administration of playing politics with rates, saying they are being blocked from raising premiums even when the increases are justified by higher costs for medical care (262). Under the guidelines, which are preliminary, insurers would have to post detailed justifications online when the proposed rate hike is double-digit. The rules also define more clearly how regulators should ascertain whether a rate increase is reasonable. Insurers believe that this will create new burdens. However, the rules continue to leave most of the regulations in state hands which are poorly organized and mostly ineffective.

The DHHS estimates the rule change would cost insurers about \$10 million to \$15 million at first and then up to \$4.5 million a year between 2011 and 2013 (262,263). The ACA has begun to help states strengthen or create rate review processes. On August 16, 2010, HHS awarded \$46 million to 45 states and the District of Columbia to help them improve their oversight of proposed health insurance rate increases. This is part of the \$250 million that the health reform law makes available to states to take action against insurers seeking unreasonable rate hikes (263). Consequently, the proposed regulation is expected to help safeguard consumers from unreasonably high rate increases by providing consumers with detailed information on proposed increases. This new proposed rate review regulation will also work in conjunction with the medical loss regulation released on November 22, 2010, to make the health insurance marketplace more transparent and in-

crease the value consumers receive for their health care premium dollars (264).

Even though most companies don't plan to drop coverage (265-267), 30% of those surveyed said that companies plan to spend less on health benefits - indicating potential benefit cuts.

The issue of enrollment of people with pre-existing conditions is thought of as one of the most humanitarian achievements of the ACA. However, the data shows that only 8,000 have enrolled in a health plan for pre-existing conditions as of November 1, 2010 (268). People who have been denied coverage by private insurers because of pre-existing conditions and who have been uninsured for at least 6 months are eligible to participate in the pre-existing condition insurance plan (PCIP). The statistics show that the idea is to give patients who have no access to private coverage because of their condition a way to get insurance, while they wait for the state based health insurance exchanges to launch in 2014. Almost 6 million Americans are potentially eligible for the program, which runs through 2013. However, because the \$5 billion in federal funding designated by the law won't be enough to cover all eligible individuals, the CBO projects enrollment will average only 200,000 a year between 2011 and 2013. The PCIP is administered by either individual states or the federal government. Twenty-three states and the District of Columbia decided to let the federal government oversee their programs. People in those areas began signing up July 1, 2010. The remaining 27 states chose to administer their own programs, their start dates varied, but all plans are up and running. Enrollment numbers vary widely by state due to a combination of factors, including differences in PCIP costs, the number of uninsured people, and the insurance terrain for high-risk individuals in each state. It is believed that the numbers are low at the present time because consumers don't know that programs exist.

Consequently, it appears that the so-called pre-existing condition provision in the ACA, which has helped few through private insurance and some through the exchanges, has provided ammunition for private insurers to raise premiums on all. Indeed, the coverage can be achieved through exchanges rather than private insurers without raising everyone's premiums.

#### **9.4 State Opt-Outs**

The ability of the states to opt-out of parts of national health reform and gain more flexibility to continue working on their own brands of health system reform

has been debated (269). Beginning in 2017, the opt-out provision in the health reform law allows states to request federal waivers to be exempted from certain requirements in the law. As an example, states could opt-out of the requirements for mandatory coverage, health insurance exchanges, and penalties for employers that don't provide coverage (8). However, states must first revise a coverage program that is at least as comprehensive and affordable as the health reform law, as judged by the Secretaries of DHHS and the Treasury. Now, the Senate is considering a measure that would move up the states' opt-out date to 2014, when most of the health reform law's key provisions, including the insurance mandate and health insurance exchanges, take effect (270). The bill is a reflection of some states programs such as Massachusetts, Oregon, Vermont, and others who spent years customizing their health systems and establishing state-directed health coverage. In addition, some of the states are also looking at a single payer system.

#### **9.5 Medical Loss Ratios**

The DHHS issued final regulations on November 22, 2010, on what health insurers must do to meet the medical-loss ratio requirement as part of the new health system reform law. Starting in January 2011, if health plans don't spend enough of their premium dollars on medical care and quality improvement, they must provide a rebate to customers in 2012. Further, insurers will need to report publically how they spend premium dollars beginning next year. The regulations also specify that insurance companies in the individual and small group markets need to spend at least 80% of the premium dollars they collect on medical care and quality improvement activities, whereas those in the large group market must spend at least 85% (263,271). The DHHS believes that these new rules, based on the ACA, are an important step to hold insurance companies accountable and increase value for consumers. DHHS officials believe that the regulations will help rein in a substantial portion of insurance company spending on services unrelated to medical care, such as executive salaries, underwriting, marketing, advertising, and other administrative costs. It is believed that these overhead costs contribute little or nothing to the care of patients and the health of consumers.

#### **9.6 Constitutionality of the Individual Mandate**

The constitutionality of the individual mandate also has been questioned (272). Multiple organizations

and lawmakers who opposed the passage of the act continue to take action against the ACA. The target of the actual and threatened lawsuits is based on several key provisions of the bill, including the constitutionality of the individual mandate and various other aspects. Constitutionality of the individual mandate takes center stage (273-278) of these efforts. On December 13, 2010, U.S. District Judge Hudson (279), in his ruling, stated that the law's requirement that most Americans carry insurance or pay a penalty exceeds the constitutional boundaries of congressional power. Thus far, of the more than 20 federal lawsuits filed against the overhaul, judges in 2 of those cases ruled in favor of the administration. However, Judge Hudson didn't grant the plaintiff's request for an immediate nationwide injunction against the entire law or against the requirement that most Americans carry insurance, which begins in 2014. The Supreme Court is ultimately expected to settle the issue after the Virginia case and other similar ones wind their way through the courts. The supporters argue that the ruling amounts to an attack on one of the law's most popular provisions – the ban on insurers denying coverage with pre-existing health conditions. They say that piece of the law cannot work unless coupled with the requirement that nearly all Americans carry insurance.

However, both sides are bolstering their arguments (280). While Republican leaders and Congress and elsewhere are formalizing their opposition to the national health reform law, 6 hospital associations, more than 75 state legislators, and others have filed or requested permission to file amicus briefs defending the health reform law. Multiple hospital associations are favoring the law, arguing that hospitals would be affected disproportionately if the law were repealed because hospitals would be forced to continue to care for millions of uninsured people. The American Academy of Pediatrics also is working on a brief supporting the health reform law.

Some believe that if the Supreme Court rules that the individual mandate is unconstitutional it will bring down the entire ACA, however, others do not see it that way (281). Interestingly enough, even though insurers continue to complain about many of the provisions of the ACA pertaining to them, they have never openly opposed the law, but rather have assisted the law to be passed, and do not support repeal (282).

Laszewski (283) writes that the individual mandate is a tepid attempt to protect the integrity of the health insurance market by forcing people to buy health insurance before they became sick. Further, the individual

mandate's fine for not buying coverage is only 1% of family income or \$95 for each family member not covered, whichever is greater in 2014; 2% of income or \$325 per family member, whichever is greater in 2015, and \$695 or 2.5% of income or whichever is greater in subsequent years. However, children are insured at half the price. Consequently these fines are meaningful for not buying insurance, but only a fraction of what a consumer would pay for health insurance. Alternatively, families would be required to pay under the health law toward their health insurance premium based upon their total family income - net of the federal subsidy as shown in Table 3 (8,21).

Consequently, if the individual mandate is eventually found to be unconstitutional by the Supreme Court there will be attempts to substitute an alternative means to protect the insurance market from the "anti-selection" or "adverse selection" that would occur as people held back on purchasing health insurance until they needed it. Laszewski (283) believes that one possible alternative to the individual mandate would be to allow consumers to purchase coverage only at limited open enrollment periods. In essence, he believes that the alternative scheme could be much more effective at protecting insurance markets, as well as far more politically palatable for consumers faced with paying either an unaffordable insurance fine or an even more unaffordable insurance premium, than the current weak individual mandate before the courts.

## **10.0 REFORMING THE HEALTH CARE REFORM IN THE CONGRESS**

Even though Republicans have gained the majority in the House of Representatives and increased their number of senators in the Senate, per above, the repeal of the law appears to be impossible. It would seem that Republicans must decide on a legislative strategy that can win votes in 2012 and at the same time fulfill the promises they made in the 2010 campaign. Thus, the question is, how far could Republicans go in modifying health care legislation without making the governing provisions unworkable (9). Another issue is related to the early signs of flexibility on the part of executive branch agencies in interpreting and enforcing new rules. This might make it more difficult for Republicans to convince private sector decision makers that the ACA is unworkable. In addition, some claim that the focus on Washington politics might overlook the actions already being taken by states and private firms to prepare for a new way of doing business in health care.

The Republicans, with substantial gains of 63 seats in the House, will have little difficulty passing bills; however, the fate of those bills lies in the hands of the Senate. Consequently, efforts to repeal or make substantial changes to the ACA will likely never reach President Barack Obama's desk for his veto and are guaranteed to receive the veto if they do reach his desk. Some have suggested that the new leaders in the House will focus on health care reform by defunding existing provisions. Consequently, the Republican leadership, apart from their individual feelings and promises, must make strategic decisions with advancing legislation, which may alter major provisions of health care reform. However, while it is conceivable that major and substantial changes might be made in health care reform, it would require compromises by Republicans and Democrats, which seem to be impossible at the present time in Washington. Some governors are seeking to promote innovative, market-based reforms within their states. States must implement major sections of the new law, but many are financially strapped and concerned about the cost of the reform and its ability to meet their population's needs. Consequently, multiple states are already seeking waivers. Even then, considering the political atmosphere, it appears that Congress will not pass any major health legislation over the next 2 years, and the health sector and private employers will be hard at work preparing for 2014, when many of the ACA's provisions take effect.

Supporters of the reform argue that accelerating health care innovation and many of the provisions would reform health care. Supporters also believe that government payment for health care is the best way to contain costs (284). However, at present, multiple countries with government run health systems, including the UK's National Health Service (NHS), is looking at its systems and reforming the power of NICE (156-171). Further, in Canada (285), the Fraser Institute's 20th annual waiting list survey provides that waiting time has risen from 16.1 weeks in 2009 to 18.2 weeks in 2010. Compared to 1993, the total waiting time to see a specialist or undergo an intervention was 96% longer.

Oberlander (286) presents a different view of the future of health care reform – beyond repeal. He describes that overturning the law would effectively de-insure 32 million Americans, deregulate the insurance industry, strip insured persons of coverage protections and enhanced benefits, and worsen the projected federal budget deficit- all while the number of people without insurance gallops upward, along with pre-

mium prices. However, all these assumptions by Oberlander (286) are questionable as discussed throughout this article.

Oberlander (286) also discusses the deficiencies of the GOP health care plan which was presented by then minority leader Boehner. While it was reported to potentially reduce the federal deficit by \$68 billion from 2010 to 2019, it would insure only 3 million additional Americans (287). Other issues related are that parts of the ACA have already gone into effect. Repealing the entire bill would mean that some Americans would lose benefits — including insurance reforms that allow parents to keep children on their plans until the age of 26 and that prohibit insurers from imposing lifetime limits on coverage. However, Oberlander acknowledges that the challenges to implementing the ACA will also come at the state level, since states are responsible for overseeing many of the law's key provisions, including expanding Medicaid, establishing health insurance exchanges for the uninsured and small businesses, and regulating private insurers. He further notes that beyond the courtrooms, the ACA is politically vulnerable to challenges, partly because it is not very popular. The public remains deeply divided over the law and the question of whether to keep, improve, or jettison it (288). Other disadvantages described about the ACA by Sage are that the law suffers from something of an identity crisis (289). Unlike Medicare or Social Security, the ACA is not a single program. Rather, it is a collection of mandates, public insurance expansions, subsidies, and regulations that affect different groups of Americans in different ways and at different times. Thus, Sage (289) believe that it should be renamed "Americare."

In reality, repeal is impossible. Some aspects of the health care law have been implemented and the public in general like aspects of these provisions. Consequently, one of the options for Republicans is that they could choose to retain popular benefits and target repeal of controversial policies such as the individual and employer mandates, or reductions in projected Medicare spending.

## **11.0 CONCLUSION**

The newly implemented health law is historic and has major advances; however, it is deficient on cost controls, creates extreme regulatory burdens, potentially raises taxes, and empowers regulators and the insurers. In essence, supporters would even like to rename the ACA as "Americare" (289).



Advocates of the repeal of the health care reform should provide alternative approaches rather than vague arguments against the ACA. Overall, some parts of the ACA may be reformed, but the ACA already is growing roots. Thus, it will be extremely difficult to repeal.

The key issues to be looked at are related to reducing the regulatory burden on the public and providers, and the role of IPAB and PCORI. Solutions need to be comprehensive and include controlling the drug and durable medical supply costs with appropriate negoti-

ating capacity for Medicare and consequently for other insurers.

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