Op-Ed

A Blueprint for Repair and Renovation of the ACA

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THE SUPREME COURT'S DECISION IN *KING V BURWELL* THIS PAST summer may turn out to be a watershed moment. The lawsuit, crafted by longtime opponents of the Affordable Care Act (ACA), challenged the federal government's authority to offer health insurance subsidies in roughly two-thirds of the states. A decision for the plaintiffs would have crippled the law's new private insurance marketplaces in those states, forcing millions of people to lose coverage. But the Court rejected the lawsuit, with 2 Republican appointees joining the 4-member Democratic minority.

Many experts interpreted the terse opinion by Chief Justice John Roberts as a message to his fellow conservatives. Repealing the law is fine, he seemed to say, but you'll have to do it the old-fashioned way, by winning elections and passing legislation. For that to happen, Republicans would have to win control of the White House and both houses of Congress, overcome or eliminate the Senate's filibuster, and coalesce around the legislation, all the while risking a political backlash from the millions of people who now get coverage through the health care law. All of these things are possible. None would be easy.

That's why, as the prospects for total repeal fade, the more interesting question may be how the ACA's architects and advocates will react—and whether they will start working more intently on their own ideas for reforming it. Remember, the ACA never lived up to their ideals. Many would have preferred a single-payer system—something that looked like Medicare, with the government providing the insurance directly. Others had in mind a scheme that resembled what you find in the Netherlands and Switzerland, in which highly regulated private insurers operate essentially as public utilities.

Common to these visions was the hope that all Americans would have insurance, that everybody's insurance would be sufficient to avoid crippling medical bills, and that on the whole, health care costs would

become much more manageable. Progress toward these goals under the ACA has been significant—more significant, perhaps, than most Americans realize—but it remains incomplete. Studies suggest that fewer people now face financial hardship because of medical bills, for example, but plenty still struggle.¹ Health care costs are rising at historically low rates, but Americans still spend more on doctors, drugs, hospital care, and related expenses than do the citizens of any other country.

The law's advocates understood this would happen. Tom Harkin (D-IA), the former senator and chairman of the Senate Health, Education, Labor, and Pensions Committee, famously referred to the ACA as a "starter home." As the law becomes more entrenched, it's natural that these architects would start to think about some repair work and upgrades. Here are 3 ideas they are likely to consider:

1. *Better protection against out-of-pocket costs.* Even before the ACA became law, copayments and deductibles in private insurance policies were rising, and many economists believe that within reason, higher cost-sharing is beneficial. As the thinking goes, out-of-pocket costs sensitize beneficiaries to the cost of medical care, thereby making them act more like consumers who will shop for better prices and think twice about interventions that might not be necessary. (Advocates for this approach call this giving people "skin in the game.")

But higher cost-sharing also has downsides, as Drew Altman, president of the Kaiser Family Foundation, recently explained in the *Wall Street Journal*: "High deductibles may be okay for people who are generally healthy and have the resources to pay their cost sharing when they need to. But big deductibles can also be a real barrier to needed care for people with moderate or lower incomes who are sick."²

The ACA has anticipated this problem by limiting the out-of-pocket costs on plans available through exchanges and then providing extra financial assistance to people with incomes below 250% of the poverty line. Those limits could be tighter and that assistance could be more generous—or perhaps available to more people.

2. *Stronger regulation of provider networks.* Insurers frequently limit beneficiaries to small groups of doctors and hospitals, because doing so allows insurers to negotiate lower reimbursement rates,

thereby holding down costs. This is not exactly a new development. Insurers have been using “narrow networks” since at least the 1980s with the advent of managed care. But today’s networks appear to be even narrower. And while the lower premiums they produce are a boon to consumers on the whole, limited access, particularly to specialist physicians, can be a real problem for people with unique or severe medical problems.

In theory, the ACA guarantees that all networks will be adequate. But it’s up to state and federal regulators to define what “adequate” is and then to hold insurers to that standard. For example, the *New York Times* recently reported that some consumers are facing staggering bills because while getting emergency care at approved hospitals, they received treatment from providers out of their networks.³ Regulations or legislation to bolster network standards and limit consumer liability could address these problems. States like California and New York have already taken such steps. Officials in other states and in Washington, DC, could do the same.⁴

3. *More aggressive price negotiations with providers.* The ACA’s efforts to control health care costs include changes in Medicare’s reimbursement formulas and in the tax treatment of private insurance. Experts aren’t sure what role these reforms have played in restraining health care costs. But it’s likely that at the very least, they have reinforced trends already under way.

But with health care costs still on track to soak up \$1 of every \$5 of income, the question remains, what steps should come next. To many of the ACA’s advocates, the answer is obvious: The federal government should start directly negotiating with pharmaceutical companies to set the prices of drugs in the same way that European nations do. In addition, some would like to see the government set uniform payment rates for hospitals, as the state of Maryland now does.⁵

Like all ideas for health care reform, each of these would involve significant trade-offs. Efforts to limit out-of-pocket spending, for example, are bound to mean some combination of higher premiums and greater insurance subsidies from the government. Some experts worry that European-style negotiation with drug makers would dampen innovation.

For these reasons, each of these ideas is likely to be controversial, much as the ACA itself has been. But narrow reforms like these represent efforts to tinker with the health care law's machinery—and to modify the existing health care system—rather than to wipe the slate clean and start over.

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