Welcome to the November-December 2016 Editor-in-Chief’s page. This editorial column focuses on efforts to reshape one of the largest health systems in the world. While much of what might happen is still some months into the future, it is worth examining the recent history of one of the most sweeping pieces of health care legislation of the past half-century in the United States and some of its subsequent implications and consequences for patients, providers, hospitals, and insurers.

When United States President Barack Obama was elected in 2008, one of his highest legislative priorities was to reform American health care. Over the next year and half, Congress developed, wrote, and amended a lengthy bill that became known as the Patient Protection and Affordable Care Act (PPACA or ACA), passed by a Democratic majority in both houses of Congress and signed into law in June 2010. The ACA, colloquially referred to as Obamacare, contained a number of key measures, including (1) mandated universal health insurance coverage, (2) the ability to purchase a health care plan regardless of preexisting medical conditions, (3) requirement of employer-provided employee health care coverage for businesses with more than 50 full-time employees, (4) requirement of minimum standards for all health plans, and (5) federal subsidies to help low- and middle-income Americans purchase health plans. Some of the requisite measures to achieve the ACA’s goals included states’ expansion of Medicaid coverage, competitive pricing of health plans through state health exchange marketplaces, and excise taxes on the highest priced private insurance plans.
The rollout of many ACA provisions began during the initial October 2013 enrollment period. Some serious problems soon emerged: (1) lower than anticipated enrollment of younger, healthier patients, tilting risk pools toward older, sicker individuals, (2) the failure of most states to establish health exchanges or to expand Medicaid, (3) the cancellation of health plans that did not satisfy minimum established standards, and their replacement by more expensive plans, and (4) phased-in reduction of payments to physicians and hospitals for care rendered to those covered by some federally sponsored or subsidized health plans. Large insurance companies have begun to leave the state health exchanges, as the so-called “risk corridor” provision that provided government offsets against insurer losses expires on December 31, 2016. When large insurers abandon the exchange marketplaces, the competition for lower-priced health plan premiums disappears.

Although some provisions of the ACA remain to be implemented, further cracks in its seams have appeared. Many healthy and usually younger adults opted for fines that were lower than their prospective health plan premiums. In other instances, those initially insured ceased paying insurance premiums but still received health care for months until their payment defaults were detected. For many, health care plan deductible thresholds have continued to rise, meaning that their plans might not pick up the costs for care received in a given calendar year. Restructuring of existing provider networks has led to disruption of numerous long-standing patient-physician relationships. Reduced hospital payments have put many smaller and/or rural hospitals out of business, reducing access to care in those often-underserved areas. On the other side of the health care cost equation, the checks and balances system on prescription drug costs has not benefited many patients, and the conspicuous lack of tort reform continues to encourage the very costly practice of “defensive medicine.” Doctors have been caught in the ACA crossfire with increased regulation of their medical practices (e.g., required and costly electronic health records, challenging metrics that affect reimbursement) with little or no recourse.

A major problem with the current version of the ACA is, ironically, its growing lack of “affordability.” Anticipating the failure of federal and state tax revenues to cover health care expenditures in all government sponsored or subsidized health care programs, there is a groundswell movement to “reform” the ACA. Such revenue shortfalls could affect nearly half of the U.S. population that is covered by some form of federal/state health plan: 18 to 20 million Americans who receive Obamacare, 55 million who receive Medicare, and 72 million who receive Medicaid. An outright repeal of the ACA in 2017 will not be possible as long as the Republicans lack a 60% majority in the Senate. However, a mechanism known as “budget reconciliation” could begin selective defunding of some program elements of the ACA, such as expanded Medicaid coverage and tax subsidies for plans purchased on health exchanges. Short of a repeal of the individual coverage mandate, no specific plan has been articulated for the fate of the millions whose insurance coverage would cease if budget reconciliations were effected. A cautionary lesson learned from the original health care legislation, rammed through by a single party and with insufficient attention to detail or consequences, is that there should not be a similar and shortsighted partisan approach to amend this complex law. Cutting to the chase, campaign rallying cries need to be tempered by careful consideration of the downstream consequences to those most vulnerable to any changes in federal health care legislation: first and foremost are patients, followed by their health care providers and their associated health care institutions. A thoughtful solution to making health care widely available and truly affordable may, like the proverbial hand-sewn quilt, require carefully chosen and frequently disparate elements that adequately consider both the significant size and social and economic diversity of the American population. For more information on the ACA, visit the following website: http://www.hhs.gov/sites/default/files/ppacacon.pdf.