The Problematic “A” in the ACA Repeal and Replace

written by Theresa Hush | March 8, 2017



Last week, my sister sent me a copy of an email that she had sent to her inner circle. It began, “I am writing you today as a metastatic breast cancer patient . . . and also as your

friend or relative who wants you to have the best resources and care if this disease ever affects your life or loved ones."

It was a plea for women to understand what would happen to breast cancer patients if the Affordable Care Act (ACA) was repealed, linked to an article. She was hoping to reach across a divide to raise consciousness about health care, especially among women. Instead, she was surprised to get pushback about the unaffordable premiums of the ACA, and why it couldn't work. She asked me if a single payer system is the solution. I struggled with a response that would clarify the economics.

My message to my sister is this: There are several paths to providing financial coverage. But only the health care industry can make it affordable. Here's why:

The Issue Is Affordability of Health Care, Not Just Insurance Economics

The ACA debate has been grounded in blurring the line between insurance/financing and health care. The effort to expand access to care—the real "A" in the Affordable Care Act—relied on traditional insurance to make that possible. Affordability was to be achieved by creating the largest possible pool of insureds, including young and healthy people. That is basic insurance economics. But that objective had no time and possibly no potential to be realized. The results were difficult for both insurers and consumers. Growing opposition to the ACA likely advanced the exit of insurers who saw no reason to stick it out.

We should acknowledge this: Affordable premiums come from affordable health care, which we do not have. When 17.8 percent

of our 2015 national outlay goes to health care and rises every year, we cannot still expect “affordable” health insurance premiums—especially if we design a system that only covers some people. If you shrink the pool of insureds, which happened in the exchanges, the premiums just get higher. Obamacare generally covered those who most needed it, so the cost was even higher on a smaller group of citizens.

Every payment system has its flaws, unintended effects and costs. This includes a single payer system. Both providers and patients learn to game the system or leave. We have only to look at the U.K. National Health Service to see that health care costs continue to go up and health care outcomes lag , with quality concerns as well. But for many other reasons—essential health care access, for example—nationalized health care in the U.K. is broadly supported. That may well be facilitated by a tax-based financing system that eliminates the need for consumers to regularly decide on the value of health care services.

No matter what the financial structure, the bottom line is that costs drive premiums (or any other system for paying health care providers, including drugs). The premiums of different groups are higher or lower according to the number and risks of people covered. Sicker people will always cost more, and older people tend to be sicker and cost more.

Can Consumers Really Be Held Responsible for Affordability?

Proposals for ACA alternatives—including the American Health Care Act introduced by House Republicans on March 6—center on tax credits and health spending accounts, which also seek to

make insurance a more affordable choice. But they do not address the costs of health care, which impact people unevenly because of their conditions. As health care costs continue to rise, the tax credits will be inadequate to offset premiums or uncovered expenses (even if coverage can be obtained initially) for traditional insurance plans. Like the ACA but not as obvious (under a "private" health insurance market there will be no publication of rates), the ACA replacements have insurance economics as well as health care affordability problems.

I want to know how my sister and other women like her will cover the average $85,800 in breast cancer treatment for the first year, alone. Are they better off simply not paying for insurance and negotiating the debt with providers, who are reportedly deeply discounting and extending payment plans? The yet-undiagnosed may choose this option.

Consumers have limited capability, at best, to make their own health care affordable. They have less capability when needed health care is time-critical and expensive, like breast cancer treatments, or when they cannot really participate in clinical decision-making. There will be casualties under the ACA replacement. There were probably also casualties before and during the ACA.

Long term, consumers can become educated; over time, their choices should be able to wield greater influence on providers and treatments. As discussed in a previous post, we might well see a revolution among patients that leads to lower costs. However, no freedom of choice in procuring insurance can outweigh the fact that consumers currently have a lesser voice

in the costs and choices of the system that is supposedly built for them. Any shift in that dynamic will undoubtedly take a long time. Too long for my sister or others to see how a rising tide of consumerism can make health care affordable and accountable to them.

Provider Cost Accountability Will Be Key to Survival—and Affordability

Health care providers under ACA Repeal have a problem. There is little doubt that patient debt will rise, as vulnerable consumers cannot pay for treatment they are receiving. Medical debt is already high in the U.S., with one in four adults under the age of 65 having past-due medical debt (the national average is 23.8 percent). While many believe that health care institutions and physicians will charge more or shift costs to other payers, as a practical matter, that is difficult to do. Most rates are already locked in with insurance companies and Medicare/Medicaid fee schedules. Unpaid services will just hit the bottom line.

The insurance system, Medicare, and Medicaid have rewarded providers by covering their escalating costs through a Fee for Service system. We will see that system shrivel away under the need to cap costs.

The repeal of both individual and employer mandates for coverage, as well as a diminishment of Medicaid coverage, will lead to an increase of uninsured and newly covered individuals. Insurance companies, freed of the ACA plan requirements, will create different benefit plans that cap costs and put providers at risk, so they don’t lose money, and these will attract consumers. Despite the current existence of Accountable Care

Organizations, the conservative drive to reduce regulations will almost certainly trend away from provider risk models in Medicare and Medicaid, eliminating those that are unsuccessful in saving money. We should expect to see these be replaced by Medicare Advantage and Medicaid Managed Care.

The year 2017 is the first year of MACRA implementation, although significant opportunities exist for providers to take a pass on the Quality, Cost, Performance Improvement, and other initiatives. Providers who delay these initiatives, however, are ignoring the ACA Repeal and Replacement patients who are hoping that they read the fine print.

My sister turns to me for help understanding the health care industry and what it might become. I am a part of that industry. For her, I want providers to hurry up. I want them to be the best they can be and to take on the mantle of health care change so fast that they will ensure quality health care will be both affordable and accessible for all the patients whose lives depend on them.

I want to say to my sister, we have your back.

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