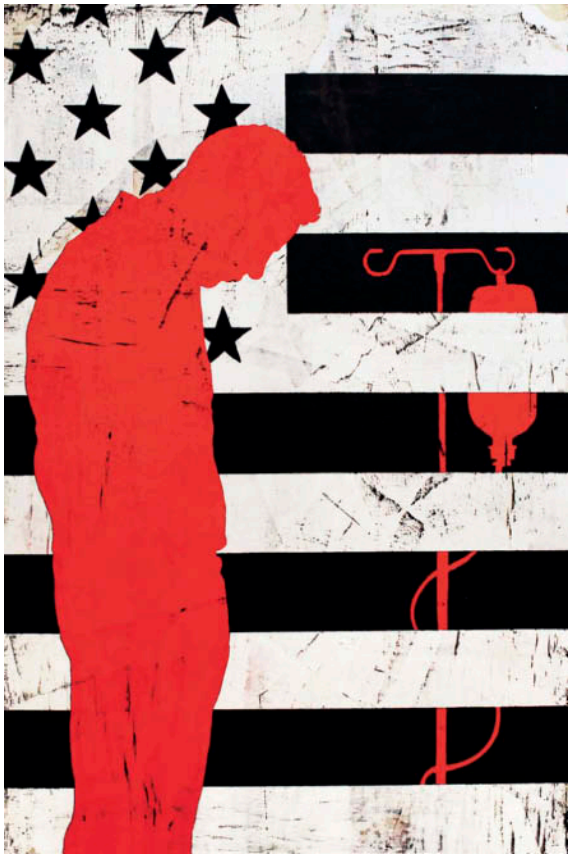
WRONG PRESCRIPTION?

The failed promise of the Affordable Care Act

By Trudy Lieberman



In July 2009, as the Affordable Care Act moved through Congress, Steny Hoyer, the second-ranking Democrat in the House of Representatives, laughed at the idea that any legislator would actually read the bill before voting on it. If such full-body immersion were necessary to support the A.C.A., he said, "I think we would have very few votes." In March 2010, just before the law passed, speaker of the House Nancy Pelosi made a similar point. Addressing a national conference of county officials, she declared, "We have to pass the bill so that you can find out what is in it, away from the fog of the controversy."

Five years after its passage, the A.C.A. is not only the most hotly debated and vituperatively denounced law of the era—it is *still* shrouded in a fog of controversy. Many Americans have no idea how the bill works or what it was designed to accomplish. In March, a Kaiser Family Foundation study found "significant" knowledge gaps in the public's understanding of the law. A third of the participants were unaware of the law's key provision: offering subsidies for the uninsured.

It is no wonder Americans have been hard-pressed to learn anything about the actual workings of the A.C.A. There has been little criticism of the A.C.A. from the left, with prominent figures such as Paul Krugman, the economist and *New York Times* columnist, acting as cheerleaders. The right has confined itself to disinformation and risible smears, with G.O.P. presidential hopeful Ben Carson memorably defining the A.C.A. as "the worst thing that has happened to this nation since slavery." A lack of clarity on both sides—and some deliberate bait-and-switch tactics—dogged the very creation of the law.

The A.C.A. was sold to the public on the pledge of "affordable, quality health care." This slogan, crafted in the shop of the Democratic pollster Celinda Lake, was incessantly pushed by everyone from grassroots advocates to top government officials, even as healthcare.gov, the new A.C.A. website, was crashing down around them in the fall of 2013. Trying to spin the disaster on *Meet the Press,* Pelosi grandly promised her viewers "more affordability, more accessibility, better-quality care, prevention, wellness, a healthier nation honoring the vows of our founders of life, a healthier life, [and] liberty to pursue their happiness." President Obama, too, repeated the mantra at every opportunity. Shortly before the exchanges established by the law opened for business, he affirmed that uninsured Americans would now have "the same chance to buy quality, affordable health care as everyone else."

Comments like these persuaded the public that the A.C.A. was

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Illustrations by Taylor Callery

a vehicle for delivering universal health care, similar to what citizens had in other industrialized nations. It was not. Instead, the A.C.A. was a canny restructuring of the American health-care marketplace, one that delivered millions of new customers to insurance companies, created new payment mechanisms for hospitals, steered more business to pharmaceutical companies, and dictated expensive, high-tech solutions for a wide range of problems.

Perhaps these would have been reasonable trade-offs for truly universal coverage. But the Congressional Budget Office estimates that even under the A.C.A. there will be some 35 million Americans without health insurance, down from about 52 million when the law was passed. At a meeting of health-policy experts in February, Shoshanna Sofaer of the American Institutes for Research suggested that the A.C.A. should be held to the highest possible standard. In three to five years, she said, we would know whether the law led "to anything vaguely resembling universal coverage." But this gets to the root of the problem. Whatever the slogans suggested, the A.C.A. was never meant to include everyone.

Essentially, the law is a means-tested program, like food stamps or Medicaid. It offers people the chance to buy private insurance online through a state- or federally run exchange, and to receive a government subsidy to help them pay their premiums. It is primarily aimed at the poor and the nearly poor: this year, 87 percent of A.C.A. enrollees qualified to receive monthly subsidies averaging $263 per person (at least in the thirty-seven states with federally run exchanges). To its credit, the law also allowed sick people to buy insurance and more of the neediest Americans to qualify for Medicaid.[1] But in the twenty-one states that chose not to expand their Medicaid programs, the poorest of the poor are ineligible for A.C.A. subsidies and, in many cases, receive no help from the regular Medicaid program.

[1] Before the A.C.A., insurance companies routinely rejected applications from people who were sick, sometimes rejecting even those who had seemingly minor conditions, like migraines. On some occasions companies would accept sick people but waive any coverage for previously existing conditions.

And what of those middle-class Americans who were supposed to benefit from the law, and were promised that they could keep the policies and health providers they already had? They've already been hit with higher premiums and higher out-of-pocket costs—and people with top-of-the-line coverage from their employers will soon find those policies shrinking, thanks to a provision of the law that encourages companies to offer less-generous benefits.

It's bad enough that the A.C.A. is fattening up the health-care industry and hollowing out coverage for the middle class. Even worse, the law is accelerating what I call the Great Cost Shift, which transfers the growing price of medical care to patients themselves through high deductibles, coinsurance (the patient's share of the cost for a specific service, calculated as a percentage), copayments (a set fee paid for a specific service), and limited provider networks (which sometimes offer so little choice that patients end up seeking out-of-network care and paying on their own). What was once good, comprehensive insurance for a sizable number of Americans is being reduced to coverage for only the most serious, and most expensive, of illnesses. Even fifteen years ago, families paid minimal deductibles of $150 or $200 and copays of $5 or $10, or none at all. Now, a family lucky enough to afford a policy in the first place may face out-of-pocket expenses for coinsurance, deductibles, and copays as high as $13,200 before its insurer kicks in.[2] Of course, these out-of-pocket caps can be adjusted by the insurer every year, within limits set by the government, and there are no caps at all for out-of-network services, which means that some providers charge whatever the market will bear. In the post-A.C.A. era, you can be insured but have little or no coverage for what you actually need.

The A.C.A.'s greatest legacy may finally be the fulfillment of a conserva-

[2] This estimate is for in-network services and includes deductibles, copays, and coinsurance. Obviously, the tab for out-of-network providers can go much, much higher.

tive vision laid out three decades ago, which sought to transform American health care into a market-driven system. The idea was to turn patients into shoppers, who would naturally look for the best deal on care—while shifting much of the cost onto those very consumers. In large part, this scheme was the brainchild of J. Patrick Rooney, whose Indianapolis-based Golden Rule Insurance Company specialized in selling policies to only the healthiest customers.

Rooney, a vegetarian who wore plastic rather than leather shoes to avoid killing animals, pioneered the marketing of high-deductible catastrophic insurance policies, which could be coupled with tax-advantaged saving accounts to pay for non-catastrophic health-care costs. These medical savings accounts (M.S.A.'s) made perfect sense to a free-market ideologue like Rooney, even if they were initially regarded as a screwball invention that ran contrary to the basic concept of comprehensive employer-based insurance. Rooney channeled millions of dollars from his company's political action committees to the campaigns of G.O.P. legislators. He walked the halls of the U.S. Capitol himself, sometimes making as many as ten thirty-minute visits a day to congressional offices.

Rooney also reached out to the media and the general public, funding groups like the Dallas-based National Center for Policy Analysis (N.C.P.A.), a right-wing think tank whose hundreds of studies, backgrounders, and presentations provided intellectual ammunition for M.S.A.'s. In time, these efforts propelled Rooney's ideas into the mainstream policy conversation. In the early 1990s, M.S.A.'s were a "marketing failure but an intellectual triumph," recalled Greg Scandlen, who promoted them on behalf of the Council for Affordable Health Insurance, also founded by Rooney.

Congress authorized M.S.A.'s as a pilot program in 1996, then made them available to all Americans eight years later, at which point they were rechristened health savings accounts (H.S.A.'s). They had arguably become a marketing triumph at last. Twenty-six million people, or about 20 percent of all privately insured Americans, currently have high-deductible health plans with H.S.A.'s or similar accounts. "Considering that H.S.A.'s were first offered in 2004," said Paul Fronstin, the director of health research at the Employee Benefit Research Institute, "twenty percent is a large number."

In other words, Rooney and his G.O.P. allies (with, it should be said, Democratic acquiescence) moved American health insurance in a direction contrary to that taken by most every other nation in the developed world. It is also contrary to the needs of those unlucky enough to get sick. Whereas insurers once asked policyholders to pay a nominal $25 or $50 for a doctor's visit or a CT scan, they now require them to foot as much as 25 or even 50 percent of the bill. What looks like a reasonably priced policy, at least in terms of premiums, can bring on sky-high bills and serious debt in no time.

For employers, of course, these policies are a bonanza: every dollar insurers save by shifting medical costs to consumers will lower the tab that employers pay for coverage. In 2011, Helen Darling, who was then head of the National Business Group on Health (which describes itself as the "only non-profit organization devoted exclusively to representing large employers' perspective on national health policy"), was quite frank about this equation. Moving from copays to coinsurance, she said, amounted to "a more subtle way to increase what the consumer pays. We are clearly seeing a march toward a more aggressive consumerist system."

That's just what John Goodman, who headed the N.C.P.A. for many years, had in mind two decades ago. Goodman is so identified with Rooney's ideas that he is frequently referred to as the "father of health savings accounts." I asked him to explain the success of consumer-driven plans. "They are the only plan out there that saves money," he told me. "They are a triumph for patient power. When you put money in the hands of employees, they spend less and are more careful buyers of care."

As it happens, patient power is mainly a benefit for employers—and insurers. Charles Kahn, who once lobbied for an insurance trade group and now heads the Federation of American Hospitals, told me that insurers have finally gotten the products they always wanted. High-deductible plans add to the predictability of setting rates, he said. With a bigger share of the risk shifted to consumers, it's easier for insurers to make money.

For patients, however, the downside has been huge. Some become so frugal that they forgo even necessary care, with disastrous consequences for their health and their pocketbook. A RAND study completed in 1982, which is often cited to justify high-deductible plans, found that patients with high out-of-pocket costs did spend significantly less—but it also found that they couldn't distinguish between necessary and unnecessary care. A 2011 RAND study reached similar conclusions; it showed that people with high-deductible plans got less preventive care, even when such care was not subject to deductibles. Perhaps they didn't understand their policies, or their doctors weren't referring them for screening. In either case, the findings run counter to one of the widely touted justifications for the A.C.A.—that it will encourage more preventive care. The studies also emphasize that in many cases, so-called consumer-driven insurance policies yield less value for patients at almost any price.

An affordability crisis is looming. Last fall, The Commonwealth Fund found that almost half of all insured adults with incomes of $23,000 or less delayed or skipped care because of high cost-sharing expenses, regardless of which kind of insurance they had. In a December *New York Times*/CBS News poll, 46 percent of respondents described health-care costs as a hardship, up from 36 percent the previous year.

According to HealthPocket, a technology company that tracks insurance costs and has plans to sell policies of its own, the average deductible this year for bronze policies, the cheapest on the exchanges, is $5,181 for individuals and $10,545 for families. Even the more expensive silver plans offer average deductibles of about $3,000 for individuals and $6,000 for families—hardly sums to sneeze at. At least some buyers of silver plans can receive additional

subsidies to help with cost-sharing.[3] For Americans with bronze plans, there is no such extra boost. The perversity of selling cheap government-subsidized policies to the poor, then sticking them with gigantic out-of-pocket costs, can hardly be lost on the 2.6 million people who opted for bronze plans on exchanges this year.

The pricing of premiums, too, calls into question a leading premise of the A.C.A. Caroline Pearson, a senior vice president at the consulting firm Avalere Health, concedes that premiums on the exchanges have so far "turned out to be lower than what policymakers expected. But that still doesn't make them affordable for people on limited incomes." Even for families with incomes between $40,000 and $80,000, she says, "the math doesn't work out." In other words, the subsidies diminish rapidly as income rises, meaning that even slightly wealthier Americans may find it hard to afford health care. This helps to explain why about 22 percent of those who signed up on the federal exchange in 2014 did not come back this year. Roughly a third of enrollees on the state exchanges also declined to renew their policies. It's possible that some of these Americans found coverage from employers, or from insurers selling policies outside the exchanges. But some surely gave up because they couldn't afford the premiums or the cost-sharing—they couldn't afford to be sick.

"We will replace the crisis of uninsurance with the crisis of underinsurance," says Jonathan Oberlander, a health-policy expert at the University of North Carolina. "Evidence from other countries does not support the notion that you have to control costs by making sick people pay more." The statistics bear out this assertion. In 1970, Canada and the United States spent roughly the same proportion of GDP on medical care: about 7 percent. More than four decades later, the United States spends about 17 percent of GDP on medical care—Canada spends 10 percent—and Americans have the highest out-of-pocket costs in the world. Canadians pay nothing to providers or hospitals at the point of service, although they may have to wait for many elective procedures—the kind of rationing used to vilify Canadian health care, almost always by Americans.

Ironically, the high cost-sharing now so prevalent in the United States has brought about its own form of rationing—by price. Americans may wait as long as their Canadian counterparts for an elective procedure, if only because they're anxiously socking away pennies to pay for it. Still, no amount of evidence from abroad is likely to prevent consumer-driven plans from becoming the cost-control method of choice for medical providers, insurers, drug makers, and employers—the same stakeholders that have always stymied real reform in this country.

Legislators whose coffers were bulging with campaign contributions from those very stakeholders made sure the A.C.A. did not include serious cost-control remedies. Indeed, both Obama and Congress were eager to embrace Nineties-era Republican nostrums, including tepid cost controls and high-deductible plans, because they hoped to avoid the sort of pitched battle that had torpedoed earlier attempts at reform. The essential elements of the A.C.A.—an individual mandate to have insurance, subsidies to help people buy it, shopping exchanges—were, like M.S.A.'s, first mentioned in academic circles by conservatives during the early years of that decade. These ideas eventually became mainstream through smart lobbying and educational efforts, and were, to some degree, enshrined in the 2006 Massachusetts law spearheaded by Mitt Romney.

In late 2010, after the fierce backlash against the A.C.A. had begun and the G.O.P. swept the midterm elections, the president appeared on *60 Minutes* to reflect on his party's drubbing. Obama acknowledged that health-care reform had "proved as costly politically as we expected"—hardly earth-shattering news. More surprising was his frank admission that the law had been taken straight from the Republican playbook. "We thought if we shaped a bill that wasn't that different from bills that had previously been introduced by Republicans, including a Republican governor in Massachusetts who's now running for president, that we would be able to find some common ground there," Obama said. "And we just couldn't."

Perhaps Obama's admission accounted for what at first seemed to be minimal opposition from mainstream Republicans as debate over the A.C.A. unfolded in 2009 and early 2010. Or maybe the G.O.P. was already confident that it could demonize the law after it passed, and thereby push the public dialogue toward the party's vision of a market-driven system that has as little government interference as possible.

If that was the Republicans' goal, they succeeded. Negative advertising in the 2012 and 2014 campaigns, and the unwillingness of many Democrats to defend the A.C.A. or even mention it on the stump, has shifted the national conversation about health care. It has almost certainly precluded any substantial consideration of a truly universal health-insurance system for the foreseeable future. It's not just that insurers, politicians, and industry lobbyists are determined to prevent such a system—even the public may have turned against the idea.

Last fall, Robert Blendon, the director of the Harvard Opinion Research Program, reviewed twenty-seven public-opinion polls conducted by fourteen organizations. One of the things he hoped to learn was whether voters believed that it was the federal government's responsibility to make sure that all Americans had health coverage. Blendon found that in 2007, as the presidential-primary season was getting under way, 64 percent of respondents answered affirmatively. By 2014, the number had dipped to 47 percent. To some degree, this decline may reflect deteriorating faith in the government's ability to solve *any* domestic problem, let alone the leviathan of health care. But Blendon also blamed what he called the "extraordinary level of paid negative advertising" aimed at the A.C.A. The ads, he told me, "raised fears that people were going to lose something under this plan."

As the Great Cost Shift continues and more Americans find themselves staggering under the weight of medical bills, support for the law could nose-dive even further. And whether Republicans

[3] *Silver-plan enrollees with incomes up to about $60,000 for a family of four qualify for these subsidies. These plans are also less likely to hit policyholders with pricey co-insurance fees.*

take the White House next year or simply hang on to their congressional majorities, they will continue to target the A.C.A. There is, for example, a sixty-five-page prescription for "Transcending Obamacare" issued by the Manhattan Institute for Policy Research that calls for a "consumer-driven health care revolution, one that could substantially improve the quality of health care that every American receives, and restore America's place as the world's most dynamic economy."

I talked to Avik Roy, one of the institute's health experts, about what this meant on a policy level. "The argument I'm making," he said, "audience by audience, paper by paper, is that we can make health care more affordable with less government intervention."

How? Roy says he isn't calling for the wholesale destruction of the A.C.A.: he has no interest in taking coverage away from people who have already obtained it, or wiping out insurance exchanges. "I think Obamacare is bad law," he told me. "But having said that, the A.C.A. has been incredibly helpful with its principle that people should shop for their own plans. That has been very beneficial in the policy debate." In Roy's view, this aspect of the legislation will make it easier to "gradually migrate" Medicare and Medicaid beneficiaries, as well as those with employer-sponsored insurance, to exchanges. In other words, the A.C.A. will eventually succeed in fulfilling the G.O.P.'s favorite health-care daydream, in which every single bargain-hunting American buys coverage directly from a private insurer.

It's instructive to look at how the A.C.A. has fared in individual states, and nowhere has it been pushed harder or denounced more vociferously than in Tennessee. During the debate over the bill, Tony Garr sent out almost daily email blasts stressing the importance of "affordable, quality healthcare" and traveled the state drumming up support for the law. A grassroots advocate and former director of the Tennessee Health Care Campaign, Garr hoped the bill would help the state grapple with an ongoing crisis. Just a few years earlier, in 2005, Governor Phil Bredesen had cut thousands of citizens from TennCare, a state-run insurance program that became too expensive largely because of cost overruns from managed-care companies. The A.C.A. held out the promise of at least some protection for Tennessee's poor.

The very poorest residents of the state are no better off today than they were before the law was passed. Presented with the chance to expand its Medicaid program under the auspices of the A.C.A., which allocated federal dollars to pick up almost the entire tab for the first few years, Tennessee declined (as have twenty-one other states).[4] This has left as many as 500,000 of the state's poorest residents without insurance, while thousands more, who qualified for subsidized coverage, are struggling with high cost-sharing and coinsurance.

Teresa Birdsong, for example, is a fifty-three-year-old woman whose annual income of about $21,600 comes from cleaning houses three days a week. She is just the sort of person the A.C.A. was intended to help—and to an extent, it has. Until recently, she was uninsured, and she suffered from high blood pressure and diabetes. Only after she bought an A.C.A. policy and got regular care and the right drugs did her blood sugar drop. "I feel good and able to work," she said. "I'm so grateful for the insurance."

Yet paying for her treatment and drugs remains a challenge. Birdsong's current policy, a silver plan, requires her to pay up to 30 percent of her medical expenses, which are partly offset by extra cost-sharing subsidies. She told me that her maximum annual out-of-pocket expense is a reasonable-sounding $550—but since the year was still young when we spoke, she had $290 to go before insurance kicked in. That's on top of $230 in bills left over from last year's cost-sharing, which Birdsong was whittling down at a rate of $30 per month. "It's all I can afford to pay," she said.

Michele Johnson, who heads the Tennessee Justice Center, argues that the law "is not perfect—but from our perspective, we can still take some imperfections." Certainly, there have been improvements. Since the A.C.A. was passed, 234,000 additional Tennesseans have become insured (about 3.5 percent of the entire population). And in February, it seemed that even more might gain coverage, as Governor Bill Haslam convened a special session of the state legislature to debate whether Tennessee should expand Medicaid.

At the hearing in Nashville, there seemed to be many reasonable arguments in favor of expansion: poor residents would be healthier, hospitals would have fewer nonpaying patients, and the state's economy would benefit. There was favorable testimony from many private citizens, as well as from the Tennessee Hospital Association. But in the end, the measure was defeated by a 7–4 vote—not a surprising outcome given the reflexive opposition to government interference by red states such as Tennessee. "Their minds were made up," Garr told me. "The legislators had already decided for political reasons they weren't going to vote for it."

One witness at the hearing was Kenneth Wilburn, a fifty-eight-year-old former state employee who was injured on the job while helping a work crew close down a correctional facility. The state laid him off, then dropped his insurance without telling him; his lapse in coverage came to light only when Wilburn had shoulder surgery and was stuck with $60,000 in bills. After his testimony, Wilburn got a standing ovation. "I was like a rock star," he recalled. "Everyone wanted to stick a microphone in my face." Still, his tale didn't sway the legislators, and once the spotlight moved on, he was back where he had started. "I have no insurance now and can't get it," he told me.

In all sorts of ways, that hearing in Nashville exemplified the poisonous politics surrounding the A.C.A. Much of the opposition at the hearing came from the Beacon Center, a conservative Nashville think tank, and from Americans for Prosperity, a national organization with links to the Koch brothers. Several hundred people wearing red AMERICANS FOR PROSPERITY T-shirts jammed the hearing room. "I'm skeptical of government-run programs," said one A.F.P. foot soldier,

[4] *Twenty-two states and the District of Columbia have embraced a full, no-strings-attached Medicaid expansion. Seven more grant coverage to eligible residents while imposing cost-sharing and other onerous requirements that further reinforce the system's inequalities. The A.C.A., incidentally, pressured states to accept Medicaid expansion by threatening to cut off all prior Medicaid funding. The option to refuse such expansion without penalty was granted by the Supreme Court in 2012.*

while allowing that he liked Medicare and had "paid into it my whole life." There was also an opening invocation and prayer against Medicaid expansion from a representative of the Cumberland Missionary Society: "O Lord, save Tennessee for Jesus' sake, and I pray that your will would be done, that *you* would be our coverage, that we would not be forced into these edicts from Washington, D.C. or any other quarter."[5]

Having failed a substantial part of the population it was actually designed to help, the A.C.A. is also wreaking havoc on the middle class, much of which had good insurance to begin with. For this blessing, Americans can largely thank the MIT economist Jonathan Gruber. Few people were as influential in crafting the A.C.A. His economic models helped determine the subsidies that people received and shaped other aspects of the law. He was the go-to guy for the press, always ready with a memorable sound bite. (On certain occasions, he may have been a little too memorable, describing the American voter as "stupid" and arguing that "lack of transparency" was "a huge political advantage" in passing the Affordable Care Act.)

In any case, the so-called Cadillac tax owes much to Gruber's salesmanship. Most Americans are still in the dark about this stealth feature of the A.C.A., which will take effect in 2018. Essentially, it's a 40 percent levy on the value of employer-sponsored health insurance above $27,500 for family plans and $10,200 for individuals, payable by employers. The provision will result in millions of workers losing their generous policies. Why? Because employers, seeking to reduce the value of their benefit packages to avoid paying the tax, will eliminate expensive options such as fertility treatments, reduce or end retiree coverage, cut their contributions to H.S.A.'s or drop them entirely, and increase the cost-sharing on whatever reduced coverage remains.

The name suggests that only a select few Americans will be hit by the Cadillac tax. In fact, the impact will be widespread. "It's going to affect almost every plan as the years go on," says Steve Wojcik, a vice president at the National Business Group on Health. "I don't think people know they're going to be affected." Eventually, the skin-in-the-game theory of cost control will reach those much higher on the income ladder, bringing us closer still to Pat Rooney's grand design for health insurance.

Gruber and other economists had long pushed for a tax on rich benefit packages in order to, as he put it, "get rid of the regressive, inefficient, and expensive tax subsidy to employer health insurance." There is a certain logic to this argument. In this country, employer-based insurance originated right after World War II, when wage controls prevented many companies from beefing up salaries. To attract talent, they began offering benefits like health insurance—and the government encouraged the practice by allowing them to write off the costs of providing that coverage.

Appearing on *PBS NewsHour* two months before the A.C.A. passed, Gruber tried to minimize the impact of the Cadillac tax. Some employers "get an enormous tax break," he insisted, "and we're going to slightly scale that back and use the money to cover uninsured people"—a move he predicted would raise $150 billion for the federal government. But he said that those Americans lucky enough to be insured by such policies needn't fear. The A.C.A. provision would move them from "very, very generous" plans to those that are "merely very generous," Gruber told viewers. As the Cadillac tax helped to control spiraling medical costs, he added, it would also result in higher wages across the board, with most of those gains going to workers with incomes under $200,000.

Despite Gruber's claims, however, it's not only the wealthy who will lose their high-quality insurance. It's also middle-income workers in unionized industries, government employees, and others in traditional manufacturing jobs. There's some evidence that companies are already anticipating the impact of the Cadillac tax. For example, 135,000 auto workers will find their benefits at risk in this year's contract negotiations. The tax will also hit people like Jeremy Devor, an engineering assistant in Illinois whose health-insurance troubles I've followed for the past few years. Devor earns about $55,000 before taxes, slightly above the national median income of $52,250, but he's had good insurance, with a very low deductible and small copays.

Even so, Devor has not been able to afford family coverage, the average premium for which shot up 73 percent over the past decade, faster than the median family income. And things are about to get much, much worse. Workers in his firm have been told to expect a change in coverage later this summer, with much higher deductibles and copays. In 2013, people in Devor's situation might have already been spending 10 percent of their income on premiums and cost-sharing. That amount is sure to increase as the Cadillac tax begins to bite. "We won't go to the doctor when we need to," Devor told me. "So untreated illnesses will progress until we are forced to go to the emergency room." Here is another practice the A.C.A. was designed to eliminate. Yet a recent poll of emergency physicians found a surge in ER visits since the law took effect.

Gruber may have believed that the Cadillac tax would control costs, and perhaps it ultimately will. But remarks he made at the College of the Holy Cross in Worcester, Massachusetts, in March 2010, just a few days before the A.C.A. passed, suggested a much deeper problem. "The only way we're going to stop our country from becoming a latter-day Roman Empire and falling under its own weight is to get control of the growth rate of health-care costs," he said. "The problem is, we don't know how."

What Gruber was saying is that we don't know how under the constraints imposed by the system's powerful stakeholders. Real cost control, as it exists in most other countries, is based on the power of the government pushing back against providers through negotiations and budgets. We don't do that here.

[5] *A few weeks after the hearing, Beth Harwell, the speaker of the Tennessee House of Representatives, appeared on a local public-affairs TV show. She explained that the committee's rejection of Medicaid expansion wouldn't prevent the governor from initiating a new conversation with the federal government in two years. By then, she hoped, America might "have a president open to a block grant and [we] will be able to put true reform into health care in the state of Tennessee." Block grants are often an invitation to cut programs and reallocate the funds elsewhere.*

During the past few years, the growth in health-care costs has actually slowed, thanks in part to a $716 billion cut in Medicare payments that was used to fund A.C.A. subsidies. The cut is permanent, and as a result, Medicare payments to doctors and hospitals will be about 11 percent lower in 2021 than they would have been otherwise. There is "no question that A.C.A. payment cuts have mattered," Jonathan Oberlander told me. "We know that in medicine, price regulation works. But a national fee schedule is a very, very difficult thing to do in the United States."

The nation's hospitals have done their best to fight any further cuts in Medicare reimbursements. In March, they took their case to the people, hoping to enlist their help in lobbying Congress. The Coalition to Protect America's Health Care, a consortium of hospitals and their state associations, ran TV ads, gathered signatures, and used social media to warn the public that cuts could mean longer waits in the ER and less access to high-end medical technology.

Charles Kahn, of the Federation of American Hospitals, elaborated for me: "Health reform is not living up to what we expected." When hospitals, which account for about one third of U.S. health spending, agreed to earlier cuts, they expected that the pool of newly insured Americans would make up the difference, along with reducing charity care and bad debt. To some extent it has, but apparently not enough to satisfy the hospitals. The idea, Kahn told me, was that the law would cover 91 to 93 percent of Americans. "It's not at the level we anticipated because the states didn't expand Medicaid," he said. "Even the exchanges have not met expectations."[6]

Unable to go head-to-head with hospitals or the big drug companies, the drafters of the A.C.A. instead embraced less contentious methods for reducing costs. These included discouraging fee-for-service payments to physicians in favor of bundled payments, which would cover all the services needed for an episode of care; penalizing hospitals for too many readmissions; and encouraging accountable-care organizations (A.C.O.'s), which are supposed to allow doctors and hospitals to coordinate treatments, thereby lowering costs and improving the quality of the actual services.

These ideas are all worth exploring. But early analysis suggests that they have had little meaningful impact. Alan Weil, the editor of *Health Affairs*, has argued that the shift to bundled payments is flawed and insufficiently disruptive—there's no evidence that it will achieve its goals. According to Scott Smith, the managing CEO of Medical City Dallas, a highly profitable hospital, the old fee-for-service model is "what our physicians want—and they want to maintain that for as long as they can."

As for A.C.O.'s, the news is a little more promising. A recent report on the government's pilot program indicated savings of more than $384 million in its first two years of operation. However, these gains were inconsistent, with some A.C.O.'s barely breaking even or losing money. And of the thirty-two organizations selected for the program, thirteen have already dropped out. One was San Diego's Sharp HealthCare, which called the A.C.O. model "financially detrimental."

The A.C.A. pinned similar hopes on digitizing medical records. Robert Wachter, the chief of the Division of Hospital Medicine at UCSF Medical Center and an expert on health IT, said that substantial savings may well materialize from such efforts, but not for five to ten years. A 2005 RAND study determined that health IT could eventually save $81 billion a year, but more recent research found inconclusive evidence of cost reductions so far. Record-keeping systems are still rudimentary, and the biggest problem is that the systems don't talk to one another: in many cases, the electronic record your doctor uses cannot be read

[6] *Overall enrollment in the A.C.A. remains lower than expected. California and New York, the states with the largest exchanges, have experienced less than robust growth, with California retaining only about two thirds of those who signed up last year—which translates into 1 percent growth for 2015, at least to date. As Caroline Pearson put it: "Does this mean growth will be smaller forever? Or will we just take longer to get there?"*

by the hospital or by another doctor trying to coordinate treatment.

There's a reason for this electronic babel. As part of the 2009 stimulus bill, the government allocated $35 billion to health IT, of which $28 billion has already been spent. Lawmakers declined to include any real standards or specifications—and nearly 800 vendors, small and large, rushed to cash in, swamping the market with more than 2,500 products. Each system creates its own record and may encode it differently from others, says David Whitlinger, the executive director of the New York eHealth Collaborative. Six years later, there are still no standards. "Congress has tried to direct the Office of the National Coordinator to mandate interoperability," Whitlinger told me, "but there's reluctance at the federal level to mess with commerce." The market is slowly consolidating, as markets always do. In the meantime, Whitlinger says, "There's a lot of money to be made."

But even if the A.C.A. wrings substantial savings out of these initiatives, and even if health-care costs stop rising, the law does little or nothing to contain the price of prescription drugs. Spending on these medications rose 6.4 percent from December 2013 to December 2014, a rate not seen in two decades, and it is unlikely to dip anytime soon.

"Drug manufacturers can raise prices to whatever they want," says Peter Bach, a physician and epidemiologist at Memorial Sloan Kettering, in New York City, who has studied the pricing of cancer drugs. "The worst thing that happens to them is that a story gets written and the practice continues." Cancer drugs in particular have proved a cash cow for Big Pharma. Not only are prices rising rapidly but, according to Bach's research, the number of new drugs approved annually has tripled since 1990.

Yet the A.C.A. reaffirmed an earlier agreement that kept the government out of drug pricing. The Medicare Modernization Act of 2003 gave seniors a much-needed prescription-drug benefit—but it simultaneously prohibited the program from negotiating prices for any of the medications it bought. When the A.C.A. came along, the president piggybacked a new deal on the old one. Medicare would not engage in price negotiations, and pharmaceutical makers agreed to discount expensive brand-name drugs for beneficiaries who had reached the infamous "donut hole" in their coverage.[7] It was a win-win: the president got a new benefit he could use to sell the law, and Big Pharma got a vast new market for its products without any price controls.

The U.S. government's unwillingness to use its negotiating power to control costs puts it at odds with almost every other industrialized nation.[8] Meanwhile, Medicare is also barred from considering the price of a drug in its coverage decisions, leaving it up to private insurers, who often have cozy relationships with the pharmaceutical industry, to supply what weak oversight there is. This means that stratospheric prices for new specialty drugs like Sovaldi, a hepatitis C treatment that costs up to $84,000 per patient, are factored into the insurance premiums that we all pay. Indeed, a ProPublica investigation found that Sovaldi and similar drugs accounted for $4.5 billion of Medicare spending last year—more than fifteen times what Medicare had spent the year before for older hepatitis medications.

The biggest winners, of course, are the insurance companies themselves—especially those that grew and consolidated over the past few decades. The law has handed them millions of new customers. Competition is unlikely to drive down costs; five big insurers now dominate the market, making it extremely difficult for newcomers to gain a toehold.

The A.C.A. did authorize two dozen nonprofit insurance cooperatives to compete with the big companies. Twenty-two remain in business, but it's not clear whether they can survive. Though the low premiums of Colorado's co-op insurer, Colorado HealthOP, helped it capture the biggest share of policies sold on the state exchange in 2015, its long-term solvency is doubtful. Iowa's CoOportunity Health, which also served thousands of customers in Nebraska, failed earlier this year, after receiving less federal support and covering more seriously ill patients than it expected. Indeed, there is some evidence that Congress—most likely at the urging of big insurers—does not want the cooperatives to succeed after all. A couple of years ago, legislators cut off funding for new co-ops and rescinded 90 percent of the uncommitted loan funds that were available to them.

If cooperatives go under, there will be even less competition. In California, for example, four big carriers sell 94 percent of the policies on the exchanges. "Not only is there significant market concentration," said David Jones, the state's insurance commissioner, "but only three insurers are selling statewide." Throughout much of California, Jones told me, this lack of competition "has tremendous implications for price and choice."

As long as market competition is restricted and there is no rate regulation (which is the case in fifteen states), rates will go up, Jones warns. Last fall, California insurers spent more than $55 million to defeat a ballot proposition that would have allowed the insurance commissioner to regulate rates. Early on, in August, 70 percent of Californians favored the measure. But in the wake of an industry-subsidized advertising blitz that linked the proposition to the A.C.A., the electorate changed its mind: in November, 60 percent voted to defeat the proposition. Even in states like New York, where regulators have so far held down rates, consumers have no guarantee that premiums won't eventually skyrocket.

It's still too early to judge whether the A.C.A. has lowered insurance premiums across the board. To help compensate carriers for the added risk of insuring lots of sick people, the A.C.A. granted them special financial protections. This extra cash stops flowing after 2017. At that point, once carriers have been able to assess their bottom lines,

[7] *Prior to the A.C.A., Medicare paid for 75 percent of an enrollee's medications until the total cost reached $2,800. At this point, enrollees hit the donut hole and were responsible for all drug bills until their annual out-of-pocket spending reached $4,550. Then Medicare stepped back in, at the higher reimbursement rate of 95 percent—but many senior citizens were unable to manage the temporary cost-sharing burden.*

[8] *The president's most recent budget breaks with tradition, giving Medicare the power to negotiate drug prices with pharmaceutical makers. Whether this provision will be included in the final bill is anybody's guess, but with Republicans controlling both houses of Congress, it seems unlikely.*

the A.C.A.'s impact will become clearer. Georganne Chapin, the former CEO of New York's Hudson Health Plan, is skeptical that any major savings are being passed along to the consumer. "You can depress premiums for a while," she told me, "but doctor and hospital costs are still going up. Carriers will just go out of business or shift costs to the people who buy the insurance. Every insurance company out there is on its own, cutting deals."

That includes Hudson Health, which recently made a deal with ENT and Allergy Associates, a group of more than 160 specialists practicing in New York and New Jersey. The group's rapid growth exemplifies what physicians all over the country are doing. Its CEO, Robert Glazer, is blunt about the broader strategy: whoever controls the patient population will have the upper hand in the battle between insurers and providers. The more people you serve, the easier it is to dictate prices.

The same battle is going on across the country, and the ultimate loser is almost always the consumer. As hospitals consolidate with one another and with physician groups, it's hard to count on competition to keep costs down. Massachusetts is the poster child in this respect. A judge there recently rejected a deal that would have allowed the Bay State's medical behemoth, Partners HealthCare, to acquire three community hospitals, largely because the acquisition could have increased local health-care spending by as much as $49 million a year. Undaunted, Partners has suggested it will focus on expansion out of state.

Shouldn't Massachusetts, which pioneered A.C.A.-style insurance exchanges almost a decade ago, be leading the nation in the law's implementation? Instead, it has the highest per capita health costs in the country, and health-care spending accounts for almost half of the state's current budget. Premiums are still rising, especially for workers in small businesses, who have been pinched by double-digit rate increases in seven of the past ten years. (The reason is that Romneycare merged the insurance risk pool, combining individual consumers and small employers—in effect, small employers subsidize individuals.) "It is no surprise to us in Massachusetts that the shortcomings of the basic framework of the Affordable Care Act mean marketplace discrimination for small businesses and their employees," argued Jon Hurst, the president of the Retailers Association of Massachusetts, in the *Boston Globe*.

The A.C.A. has meanwhile ushered in new product-line opportunities for insurers and tech companies alike. HealthPocket, the insurance-tracking firm, is planning to introduce supplemental policies—i.e., insurance to be purchased in conjunction with A.C.A. policies. The idea is that consumers can compensate for their punishingly high deductibles and cost-sharing with a *second* policy. Score one for inefficiency! HealthPocket CEO Bruce Telkamp sees the new policies as a potential gold mine. "Long term, I believe, the A.C.A.-supplement product category could be as significant as the Medicare supplement is today," he told me. "There will be millions of plans sold each year in five to seven years."

What's the downside for policyholders, besides shelling out for more insurance? The maddening multiplication of plans, prices, and features will make it harder than ever to understand who pays for what and how much. This confusion is exactly what happened with Medigap policies, which were designed as supplemental plans for Medicare beneficiaries, before Congress strictly regulated them in the early 1990s.

Other companies, new and old, are muscling into the price-information sector, in which bots scan online databases to find the best prices for MRIs, CT scans, mammograms, and so forth. The business proposition? If people approach health care as consumers, they'll hunt for a bargain on gallbladder surgery, maternity care, or other procedures whose prices vary widely. One company hoping to cash in on this potentially lucrative opportunity is Healthcare Bluebook, based outside Nashville, which uses public and private data to collate prices and sells them to employers to share with their workers. (It also offers some free data for the public.) Not surprisingly,

CEO Jeff Rice views his business model as a kind of civic service—a blow struck on behalf of transparency. "When people know how much things cost," he told me, "they will naturally seek a good value, and that will bring prices down."

Rice, along with most proponents of consumer-driven health care going all the way back to J. Patrick Rooney, assumes that we're talking about a traditional market. In their view, choosing medical treatment should be like buying a car or canned peaches. If consumers have the right information, if there is sufficient transparency regarding prices and services, they will make the right choice.

But buying health care is not like buying a car. Most people aren't going to sit up on the gurney, tell the surgeon that the hospital is too expensive, and take their liver transplant elsewhere. To get well, they need to trust their physicians—and since even the Yelp-like websites designed to rate practitioners and hospitals are notoriously spotty, many patients will stay with the tried and true. Meanwhile, insurers are tightening their provider networks, cutting deals only with the physicians who offer *them* the best prices. As a result, patients may actually have fewer choices. If a better doctor for your needs is not in your carrier's network, you may be stuck paying out of pocket for superior care, or taking whatever your insurer offers and hoping for the best.

Shopping for the right insurance policy is no easier. Ideally, you would be able to factor the appropriate level of risk into your decision—but most people cannot. Paul Borghard, an upstate New York sheep farmer, recently learned this lesson the hard way. Borghard is hardly a novice when it comes to fine print and fiscal niceties—in fact, he has a graduate degree in business—and he spent days sifting through his options on the state insurance-exchange website. "I don't know how the ordinary Joe who gets on that site can decipher whether he needs a higher copay, more coinsurance, a high out-of-pocket maximum, the drug deductible," he told me. In many cases, the website said one thing about benefits, the insurer said another. "When I picked a plan, I didn't know exactly what the benefits were. I didn't make an educated decision. I ended up with a decision by default."

Only three companies sold policies in his area, on the New York–Vermont border. Two didn't cover services in Vermont and New Hampshire, where he sometimes sought treatment. Did the remaining carrier include the providers and facilities that Borghard already used? He called the Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire, and put the question to them directly. Good news: the hospital accepted his insurance.

Borghard signed up. At that point, he was perfectly healthy—but soon afterward, he developed a health condition and sought a consultation with a specialist at Dartmouth-Hitchcock. Then he learned that he had no coverage. The problem was that in order to keep his premiums down, he had purchased an HMO, which requires you to use doctors in a particular network; only a PPO, which allows you to go outside the insurer's network, would have covered his visit to Dartmouth-Hitchcock. None of the materials he had examined earlier had made this exclusion completely clear, and in any case, Borghard wasn't sick when he made his choice. Now he was stuck paying $900 out of pocket, simply because he was unable, as he put it, to "look into a crystal ball and know what my medical services and needs would be for the coming year."

Yet the fiction that people can control their own health-care destiny, and the narrative of the rational shopper, continue to delay the day when the United States will have to make real decisions about our high-priced, unequal, and insanely inefficient system. The A.C.A. didn't invent this system, of course. But because of a failure of nerve and the immense power of health-care stakeholders, the A.C.A. has reinforced and accelerated many of the system's most toxic features. Who should get quality health care? The poor, the rich, the vast middle in between? And how should we pay for it?

King v. *Burwell,* the latest legal challenge to the A.C.A., will be decided by the Supreme Court just as this article goes to press. The case hinges, absurdly enough, on a single four-word clause—"established by the state"—which, according to opponents of the law, prevents Americans from receiving subsidies on policies they have purchased from federal exchanges. The court's verdict will determine the future of the law. But putting aside whatever decision may come down, it's fair to ask: Is the A.C.A. better than nothing? Even with the law's considerable defects, the answer is probably yes. It has expanded the number of the nation's insured by 17 million, at least for now. And if the A.C.A. survives *King,* the decision may offer a fresh opportunity to assess the law's shortcomings, and maybe even to fix some of them.

As I've suggested, the shortcomings are numerous. Too many Americans are still excluded; the process of buying insurance remains incredibly complicated; there is little regulation throughout much of the country; and millions of people are saddled with huge out-of-pocket expenses and lack the coverage they truly need. Fixing these problems would be a huge step forward. But even if that can be done, we will be left with the system's fundamental flaw: high costs and our inability to effectively control them. The only way to fix *that* is to attack the stranglehold that drug companies, insurers, hospitals, and doctors have on the machinery of health care in this country—a bold move that has so far frightened away almost all contenders.

On a cold February night, New York assemblyman Richard Gottfried met with the Chelsea Reform Democratic Club in Manhattan. Gottfried pushed a new proposal for reforming health insurance, a plan he called New York Health. He argued that America rations care according to wealth, and that people are still going without. Some in the audience were skeptical. One woman worried that good doctors would leave the state, and that lines would snake around the block to see an average one. An audience member stood up and posed the question on everybody's mind: "Wasn't the Affordable Care Act supposed to solve all this?" ■