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Commentary

Does the Accountable Care Act aim to promote quality, health, and control costs or has it missed the mark?

Comment on "Health system reform in the United States"

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Abstract

McDonough's perspective on healthcare reform in the US provides a clear, coherent analysis of the mix of access and delivery reforms in the Affordable Care Act (ACA) aka Obamacare. As noted by McDonough, this major reform bill is designed to expand access for health coverage that includes both prevention and treatment benefits among uninsured Americans. Additionally, this legislation includes several financial strategies (e.g. incentives and penalties) to improve care coordination and quality in the hospital and outpatient settings while also reducing healthcare spending and costs. This commentary is intended to discuss this mix of access and delivery reform in terms of its potential to achieve the Triple Aim: population health, quality, and costs. Final remarks will include the role of the US federal government to reform the American private health industry together with that of an informed consumer.

Keywords: US Healthcare Reform, Obamacare, Affordable Care Act (ACA), Healthcare Exchanges, Triple Aim

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President Obama's commitment for health reform was primarily to expand access to the fifty (50) million uninsured by providing government financing to purchase private health insurance that includes coverage for prevention and treatment. Financing occurs in two ways (1):

1. Expansion of state Medicaid programs to 133% of Federal Poverty Level (FPL) and;
2. Subsidies for health insurance based on income level up to 400% of FPL.

The Affordable Care Act (ACA) also offers some financial incentives and penalties to re-engineer the organization and delivery of care. For example, incentives for providers to form Accountable Care Organizations (ACOs) and medical homes to provide an array of health services (primary and specialty) to effectively manage and coordinate care especially for those with chronic conditions. Another component of the ACA includes re-organizing care for Medicare beneficiaries in fee-for service plans by imposing penalties to hospitals for re-admissions and acquired infection rates among these Medicare patients. While these targeted mechanisms are limited and voluntary they do offer innovative strategies to help re-design the organization and payment for Medicare patients who are among the most costly to cover.

Healthcare reform and the Triple Aim

The Triple Aim of improving population health and the patient experience of care, while reducing per capita cost was introduced by the Institute of Healthcare Improvement (IHI) in 2008 as a rationale for creating and improving health delivery systems. These provide some success criteria for access and delivery reforms in the ACA. Table 1 provides some examples:

- The design of basic health insurance offered through the ACA includes preventive services that are covered without any cost sharing to promote screening and early detection and thus promote population health. This feature has been extended for Medicare beneficiaries too. The structure of the basic health plan includes a comprehensive set of benefits. Cost sharing for premiums for eligible enrollees (who earn 100–400% of FPL) are based on a sliding scale to keep the premium affordable (1).
- Delivery changes like the ACOs and medical homes to improve the coordination and integration of healthcare strive to reduce duplication, waste, and ultimately lower costs while enhancing patient satisfaction with care.
- Lower hospital re-admissions and acquired infection rates for Medicare patients to reduce hospital costs and improve patients' experience with care.

Delivery reform: case of Accountable Care Organizations

ACOs are provider networks that are rewarded financially if they slow the increase in patients' healthcare spending while maintaining or improving the quality of care delivered (2,3). These partnerships among physicians and hospitals are considered a key delivery reform to transform the uncoordinated way both outpatient and inpatient care is provided to Medicare fee-for-service beneficiaries. The rationale to incentivize this change in the delivery of hospital care to Medicare patients is that ACOs allow Medicare beneficiaries freedom to choose providers and to reward those participating in ACOs for

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Table 1. Selected access and delivery reforms and potential effects on the Triple Aim

Reform	Population Health	Quality	Costs
Basic health coverage	Preventive care without cost sharing	Comprehensive benefits	• Cost sharing based on income; • Provider risk payment
ACOs and medical homes		• Improve care coordination and; • Patient experience with care	• Provider Risk payments; • Reduce duplication and waste; • Reduce use of inpatient services by coordinating outpatient care
Inpatient care for Medicare patients in fee-for-service health plans		• Improve inpatient experience and; • Quality of care	• Lower hospital re-admissions; • Acquired hospital infection rates

delivering quality outcomes and lower costs. There has been considerable growth in the number of ACOs and number of Medicare beneficiaries affected since the passage of the legislation. Three hundred and sixty (360) ACOs have been established, serving over 5.3 million Americans with Medicare (2). A recent study suggests that ACOs are more likely to form in geographic markets with large hospital systems, large groups of primary care physicians, and hospitals that have experience with risk sharing (3). Thus, ACOs may be better suited to operate in markets with the infrastructure (physicians and hospitals) and experience to coordinate care.

The extent that any parts of the Obamacare can be deemed transformative will depend on whether and how each reform area meets the Triple Aim goals. A closer look at how the legislation intends to improve population health appears based on the provision of primary care for screening and early detection. No cost sharing for such preventive services is an example of the legislation's intent to increase access by removing financial barriers. However, the key determinants of population health extends beyond the delivery of medical care services given to include social, psychological and physical environments (4). Therefore, measures of health status and longevity are key metrics to include for evaluating whether healthcare reform is improving the health of Americans. Yet the Affordable Care Act focuses on access to preventive medical services that are far less likely than lifestyle, environment, and socioeconomics to improve the population health. These along with related quality of care and cost measures need to be part of a systematic evaluation of these policies.

Early findings

The January 1, 2014 start for health coverage for new enrollees was delayed by a rocky sign up period that began October 1, 2013. Many individuals faced long waits and technical glitches that impeded their ability to enroll in a health plan. The Centers for Medicare and Medicaid reported that there was about 3 million people who enrolled during January 2014 (5). Data indicate that young adults 18–34 years comprise about a third of new enrollees. This enrollment among young adults is consistent with expectations that young healthy people are not likely to sign up first as compared to older adults with more age related health needs. However, these early counts are engendering lively discussions re: the value of the basic health insurance coverage in the ACA. Care and caution need to be exercised regarding making judgments based on very preliminary and short-term information (6).

Role of the American government

American health industry is an insurance based health delivery system that involves an extensive network of private insurers and providers. Nonetheless, the US government has actively supported the country's private healthcare industry as well as other major national industries (7). For example, the US government has reimbursed and paid for private providers and vendors for health services rendered to elderly and poor via Medicare and Medicaid; invested in the education and training of physicians; and development of infrastructure (buildings, equipment, therapeutics, and technology). Therefore, given the government's active role in the growth and development of the health industry, it is consistent for the government to be actively involved in its reform.

It is important to note that American healthcare reform occurs periodically with major reform like ACA occurring less often (8). A primary focus of the ACA is to increase access to health insurance among the uninsured and as such be more similar to other developed countries in terms of commitment to the sick and vulnerable (9). McDonough underscores the need for American reform by noting that less developed countries are more committed to the underserved than the wealthy US.

Understanding the role of the government in the national health system is an important contextual factor that will determine the generalizability of national reforms globally. The government's role in the US is primarily as payer not as owner or provider. The US government has been involved as a major payer since 1965: funding insurance to the elderly and poor.

As McDonough accurately cautions, Americans' interest in health policy has not extended outside its borders. However, many nations are tackling rising health costs due to demographics and delivery inefficiencies. China is a case in point. Its market based health system is similar to the US and its current reforms can provide some guidance for the US. China is a country whose health service delivery is based on a complex system of different health insurance programs. The economic development in China in 1970s led to a decline in governing funding for healthcare facilities and infrastructure. Since 2009, China's health industry has been reforming. The Chinese government has invested funds to provide public health insurance and modernize the delivery system. There has been insurance reforms that include coverage, infrastructure, and workforce (10). As data from its health reform emerge, it is likely that lessons learned may be generalized to both of these countries given the active role taken by both governments to reform the insurance foundation in their respective national healthcare delivery systems.

Conclusion

To say American health reform is complicated is a gross understatement. As the implementation of health plans and exchanges offered in the ACA gets underway, early results are providing fodder for the campaigns for midyear 2014 Congressional elections. Both political parties are packaging early results to serve their own interests adding to the publics' confusion re: actual what the healthcare reform is doing. A recent article (11) reported a case of a young adult and his son living in state that chose not to expand its Medicaid program. This has been heralded by some as an example of the coverage gap created by the ACA rather than result of a state's refusal to expand its Medicaid program included in the ACA.

However, the vast amount of misinformation requires the citizenry stay informed with accurate data. Health policy centers like the Commonwealth Fund (12) and Kaiser Family Foundation (13) are tracking the rollout of the ACA and providing timely and evidence based analysis to help evaluate whether and how US health reform achieves the Triple Aim in comparison to accomplishments in other nations. At the least, the ACA is reinstating healthcare as a national priority worthy of attention and dialogue. Hopefully, American healthcare reform can motivate citizens to be well informed consumers of services willing to take action to promote individual and collective health.

Ethical issues

Not applicable.

Competing interests

The author declares that she has no competing interests.

Author's contribution

CM is the single author of the manuscript.

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