Obamacare: Next steps in US healthcare reform

Obamacare is here. As he affixed his signature to the Patient Protection and Affordable Care Act on 23 March 2010, President Obama signed into law what many observers view as one of the most important changes to the American healthcare system since 1965. If all goes as planned, by 2019 (when the law becomes fully operational), the USA will have largely erased a major blot on its healthcare system.

The US spends more per capita on health (US$ 7421 in 2007) than any other country,[1] but 17% of its population (approximately 42 million people) does not have access to healthcare. Yet, healthcare expenditures keep increasing at an unsustainable rate. The Patient Protection and Affordable Care Law is an attempt to square this circle—provide access to healthcare to those without, and to constrain the rapid growth of healthcare expenditures ('to bend the cost curve').

The American healthcare system relies largely on employer-based health insurance to provide coverage, i.e. health insurance is a (well-intentioned) perk of employment. The uninsured in the USA are largely those who are unemployed, the employed poor whose employers do not offer health insurance (or are unable to pay the premiums of the offered insurance), and the wealthy. The present law increases coverage by adopting two major approaches: (i) expanding Medicaid (the government health insurance programme for the poor)—it does this by removing restrictive eligibility criteria, and allowing persons earning up to 133% of the Federal Poverty Level (FPL; which was US$ 29 327 for a family of four in 2009) to qualify; and (ii) an 'individual mandate'—all US citizens and legal residents are now required to have health insurance; with a financial penalty for not doing so. These individuals (and their employers) will be able to shop for health insurance at new health exchanges, which will set rules allowing for easy and transparent comparison of health plans.[2] In addition, there is a generous government subsidy (on a sliding scale for persons earning 133%–400% of FPL) to help pay for plan premiums. By 2019 (when the law comes into full effect), an additional 40 million Americans will gain access to the healthcare system via these two mechanisms.

The government estimates that the law will cost US$ 940 billion over the next 10 years. In an attempt to curtail its costs, payments to healthcare providers will be cut, new fees will be imposed on health insurers and drug companies, and wealthier Americans will be taxed more.[2] The law has a myriad other provisions, though none are as radical as the individual mandate. New regulations on the health insurance industry now forbid discrimination on the basis of pre-existing conditions, prohibition of lifetime benefit caps, and rescission of coverage when one becomes ill. Businesses with more than 50 employees must offer health insurance to their employees, or pay strict fines. Payments to primary care providers will increase, at the expense of other physicians.

What's not likeable in this package?

According to right wing critics, a programme that costs nearly a trillion dollars just when the economy is recovering from a financial meltdown, is unconscionable. Greater involvement of the government in price setting of physician payments, increased insurance regulations, and additional taxes on the rich are seen as the death knell of the free market economy. The Republicans threaten to repeal the law once they gain power in Congress. On the other hand, left wing critics feel that the plan does not go far enough—they would prefer a single-payer government-run system akin to that of Canada. They point to the exclusion of illegal immigrants from the law's provisions as an example of its stinginess, and fear that insurers and providers will exploit legal loopholes to subvert the law's intent.[3]

What does the future portend?

History shows that entitlements, once created, are near impossible to rescind. The law provides health insurance to 40 million Americans who did not have it before. These are new customers for insurance companies, new paying patients for physicians and

hospitals, and they have enhanced financial wherewithal to consume the wares of pharmaceutical companies. No wonder the stocks of insurers and pharmaceutical companies rose on Wall Street after the bill was signed. Future healthcare debates in the USA will not deal with the issue of access, but with the issue of cost control.

Are there any lessons for India?

At a micro level, as the private health insurance industry grows in India, we must ensure that there is a level playing field. Provisions such as a standard package of essential health benefits providing a comprehensive set of services, greater transparency from insurers (in terms of the proportion of money spent on clinical care, premium rate setting and increases, etc.), standardized templates for insurance policies, eliminating lifetime limits on coverage, guaranteed issue and renewability, could be the starting point of a dialogue between the government and insurers.

At a macro level, the provisions of the law serve to highlight what is really needed in India. A mandate to obtain insurance—individual or employer—is a difficult proposition in a situation where illiteracy and an underground economy make such mandates a challenge to implement. Given that 80% of healthcare expenditures in India are private, physician and hospital payment reform espoused in the American bill are moot issues for Indians. These points underscore the critical role that the government has in providing healthcare to the vast majority of Indians, especially to poor and rural citizens who are often bypassed by the private insurance market. The government must strengthen its healthcare infrastructure, failing which it must put into place mechanisms that facilitate the entry (and protection) of the underserved into the insurance market.

We know it can and must be done—the time is now.

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AMARDEEP THIND
Canada Research Chair in Health Services Research
Department of Epidemiology and Biostatistics
Department of Family Medicine
Schulich School of Medicine
University of Western Ontario
Canada
athind2@uwo.ca

FRED HAGIGI
Department of Health Services
UCLA School of Public Health
Los Angeles
California
USA