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A call to oncologists to right the wrongs of the Affordable Care Act

We must lay hold of the fact that economic laws are not made by nature. They are made by human beings.

—Franklin D. Roosevelt

Americans are in a unique predicament wherein they feel entitled to health care but do not want to be required to pay for it. Until they get sick, that is. And to be honest, who can blame them? Any meaningful discussion of the Affordable Care Act (ACA) and the health care system suffers from the way we frame the issue. As a physician and lawyer, I am a supporter of the ACA, but I also think there is more work to be done. And some of this work needs to be done by physicians. When I discuss this with physician colleagues, I find they often become hostile and defensive, expressing concerns that the health care law is a direct assault on their livelihood and is helping no one. Yet, there is a different side to the story on the legislative and policy ends. As physicians continue to do what they have done for decades, adapting to changing patient needs and struggling to keep up with a full docket, endless paperwork, and the constant influx of new technologies, I fear that they continue to fall behind in the greater battle of special interests in which they, along with their patients, have the most to lose.

1. Oncologist views of the ACA

Many oncologists supported the passage of the ACA into law and with good reason. Our patients can no longer (1) be denied coverage due to pre-existing conditions; (2) be charged more because of their health status; (3) be faced with annual or lifetime coverage limits that cause a sudden termination of care; (4) be denied preventive services for cancer screening. At its heart, oncology is about advocacy for our patients—to get them the treatments they need, to direct them to the right clinical trial that will extend their life for several months or years, to provide them with dignity and comfort when we have nothing left to offer. The question is how do we do this in an evolving and increasingly political and regulatory environment that often feels unwelcome to us? I am reminded of a story shared by a physician and representative of the local medical board in 2010. Prior to the passage of the ACA, he spent many months trying to set up a meeting with his local Senator to discuss physicians' reservations about the law. When he arrived with nine other specialists for the long-awaited meeting, he was promptly turned over to the senator's 25-year-old aide for a short but polite briefing of his concerns greeted with silent nods. In fact, he never met the Senator or heard back from him. This is hardly unusual. The old adage on Capitol Hill is that physicians are notoriously difficult to speak with. They harp on about physician reimbursements and how hard they have it and fail to understand, let alone embrace, the big picture.

And what is this big picture in the eyes of lawmakers? Physicians are just one part of a massive and flailing health care system that is costly and inefficient, has poor outcomes, and is unaffordable. Add to this a constant barrage of lobbyists for trial lawyers and the insurance, pharmaceutical, and medical device industries, and it is not difficult to appreciate why physician interest groups have little sway. In this increasingly murky cauldron of special interests, it is physicians and most importantly our patients who are harmed. We may look at the ACA and feel that we are martyrs in part or that our duty is sufficed in tolerating it. After all, it is an enormous step forward to expand insurance coverage to millions of uninsured. It is a milestone that insurers cannot deny coverage based on pre-existing conditions. Yet this is not the whole story. Millions of our patients with chronic diseases have paid for insurance throughout the years, yet are being left behind in states that do not expand Medicaid coverage or find themselves too wealthy for federal subsidies but too strapped for cash to keep paying premiums. As copays and deductibles are on the rise, many of our cancer patients find that their health care costs are consuming an unsustainable proportion of their income [1].

As oncologists remain occupied in the trenches of health care practice, the ideological battles in the legislature's office and the media wage on, often veiling the progress of health care reform while obscuring the many challenges and deficiencies that remain. It is time for physicians, particularly oncologists, to step out from under the hyperbolic broadcasts of doom and political bantering to get their facts straight and act as advocates— advocates for their patients and the health care system as a whole. But if we are to do this with a clear head, we first need to get a few distractors out of the way: physicians are not the victims of the ACA and the battle over political ideologies is neither doing a service to our patients nor ourselves.

2. Physicians are not the victims of the ACA

The goal of the ACA was to bridge the economic divide between payer and payee and the vast majority of the legislation fell on the insurance side of this equation. To put that more concretely, with over 800 pages of text and 11,000 pages of regulation written relating to the law, language regarding a change to physician fees is mentioned only 15 times while insurance payment modifications appear over 700 times.

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Physicians carry a unique status within the frameworks of the legal system. We are allowed to regulate ourselves. We run our own medical licensing administrations and, in some states, our own hospitals. We also define our own standard of care in malpractice law, an unprecedented rarity in the jurisprudence of tort law. We decide which insurances we accept and even which patients we see. The law is not taking any of this away from us; nor was the ACA intended to be a war on doctor's salaries or livelihoods.

The problem the ACA addresses started as an economic one before it became an ideological battle. By 2009, there was a massive and ever-expanding deficit and the government could no longer look the other way. Additionally, statistics we all recognize were becoming increasingly problematic. Chief among these was the number of uninsured Americans, a number that from 2002 to 2012 was estimated to have increased from 32 to 50 million. This rise was aided in large part by the loss of jobs during the recession but also by the involuntary discontinuation of insurance plans often due to a myriad of unethical insurance practices, including clauses regarding pre-existing conditions and lifetime caps amongst others. This lack of insurance together with other factors made medical bills a major contributor to personal bankruptcies so that between 1988 and 2004, medical bills had become important in more than 60 percent of bankruptcy filings [2]. But the uninsured were not the only factor—rising health care costs were increasingly seen as unsustainable and I might add, not as a result of doctor's fees that accounted for only 9% of the health care budget. By 2010, for example, the largest drivers of cost [3] were chronic illness ($1.9 trillion) [4], health care disparities ($309 billion) [5], health care and insurance administration ($145 billion) [6], lack of insurance ($84.9 billion) [7], medical errors ($17 billion) [8], and prescription drug expenses ($2.5 billion; eg, Medicare prescription drug donut hole [9]) [10]. Yet, by the tail of the recession in 2009, with private health insurance a one trillion dollar business, profits at US health insurance companies had increased by 56% with America's five biggest companies reporting a combined profit of $12.2 billion [11]. Add to this the fact that outcomes with regards to diabetes, heart disease, and infant mortality were found to be worse in the United States than in first world country cohorts spending less on health care and the inevitability of change becomes apparent.

As it turns out, the text of the law reflected the scope of the problem. The ACA was designed to: (1) end predatory insurance practices, (2) expand access to insurance coverage, (3) cover preventive care, (4) address health care disparities, (5) fill the Medicare prescription drug "donut hole," and (6) incentivize reducing medical errors and improving health care quality. Unfortunately, it was enacted with only a limited ability to contain health care spending, a major flaw that has been discussed in detail elsewhere [12]. Indeed, what was omitted or drafted out of the law and where the burden of these omissions falls is not as clear. That is where our work begins.

3. It is patients who carry the burden if the ACA comes up short

Since the main focus of the law is cost and redistributing that cost, the essential question is who is carrying the burden of that cost? The ACA contains a number of cost containment provisions including (1) an independent board to adjust and reduce Medicare spending [13];(2) a 40% non-deductible "Cadillac" tax on employer-sponsored health coverage that provide high-cost benefits [14];(3) quality reform measures, such as penalties for hospitals with high infection rates; and (4) the creation of group medical practices (accountable care organizations, or ACOs), whose goal is to lower health care spending and improve quality of care by tying physician payments to quality metrics. Although physicians may be the doorkeepers to many of these cost-containment provisions, the real potential victims are the patients. When the system does not work, the cost is pushed back onto patients as increased premiums, deductibles, and copays.

Despite numerous failed prior health care reform attempts, the ACA was signed into law in 2010, aided in part by adroit legislative maneuvering. In the process, it had to endure a year of redrafting text and trading favors in Congress, and after its passage, two Supreme Court challenges and innumerable attempts to repeal the law. Yet, intent and implementation are not one and the same. If addressing the glaring disparity between health care costs and outcomes and the quickly growing marginalized segments of society that were being deprived of even basic health care was its purported intent, the ACA did not go nearly far enough. As physicians, we were and continue to be the first to witness the failings of our health care system on an individual patient basis; and, without hesitation, it should be our duty to advocate for our patients.

4. The partisan battle on health care reform is wasting everyone's time

We have all heard the endless rhetoric from the health care act naysayers. Congress voted to repeal the ACA over 60 times. The most recent attempt, a partial repeal, passed both houses of Congress in Dec 2015. This time, the repeal attempt was tied to a funding bill (defunding Planned Parenthood) that placed the bill under the procedural rule of reconciliation that allowed the legislation to pass the Senate with only 51 votes and without the threat of a filibuster. The bill was vetoed by President Obama in January 2016 and is not likely to become law anytime soon. If history is any judge, the ACA is here to stay.

Indeed, implementation of the ACA has been far from perfect. Health care premiums and deductibles are rising. In 2016, the average premium increase will be about 10.1% [15], a bit higher than expected but not far from the average 5%–10% increase in years before the law. Additionally, insurance enrollees in some cases are having less choice in physician selection due to narrow networks. Physicians are also feeling the pressure to consolidate into larger hospital or health care networks to comply with new regulations and overhead costs. But I would argue these processes were inevitable regardless of the system we selected and had begun even before the ACA was implemented. Even for Supreme Court Chief Justice John Roberts, whose ideological contempt for the law was tempered by not wanting to be remembered as the Chief Justice who vanquished a historically important piece of legislation, the time was ripe for a change in the government role in health care and that force could not be quelled. To put it in other words, becoming embroiled in the partisan battle on health care reform is wasting time, and depriving us of an opportunity to seek out the true weaknesses of the law and begin the process of remedying them.

Putting politics aside, what should we as physicians do to move health care reform along in a manner that provides the widest coverage without further eroding our ability to practice the best medicine? I would argue we must rally behind a single payer system, support an expansion of the Medicaid program, and demand genuine tort and malpractice reform. Only by advocating for all of these as a package will our credibility be uncompromised and our influence enhanced. Below I look at these three issues.

5. Failure #1: the lost opportunity for a single-payer system

It is interesting that despite being the obvious villain and target in the health care economic overhaul, the health insurance